DOCUMENT RESUME

ED 398 464 CG 026 918

TITLE	Directions in Mental Health Counseling, 1992.
INSTITUTION	Hatherleigh Co., Ltd., New York, NY.
REPORT NO	ISSN-1062-0788
PUB DATE	92
NOTE	268p.; Continuing Education credit may be available based on completion of questions following each section (contact publisher for requirements).
AVAILABLE FROM	The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022; phone: 800-367-2550, 212-355-0882 ($195 per year).
PUB TYPE	Guides - Classroom Use - Instructional Materials (For Learner) (051) -- Collected Works - Serials (022) -- Tests/Evaluation Instruments (160)
JOURNAL CIT	Directions in Mental Health Counseling; v2 n1-12 Jan-Dec 1992
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Acquired Immune Deficiency Syndrome; Cancer; *Counseling; Counseling Services; *Depression (Psychology); Existentialism; Heart Disorders; Incest; *Mental Disorders; *Mental Health; Psychotherapy; Sexual Abuse; Special Health Problems; Stress Variables; Substance Abuse; Work Environment
IDENTIFIERS	Codependency; Gambling

ABSTRACT

A collection of 12 lessons, this volume covers a wide range of concerns in mental health counseling. Each piece begins with an editorial comment, followed by an introduction which outlines the scope of the problem under consideration. The main body of each paper presents a clear, easily understood analysis of the subject under consideration. A list of further sources the reader can consult appears in the back. Questions based on the lesson, which can help the reader gauge how much of the material he or she has understood, are listed at the end of each article. Lessons in this volume are: "Stress in the Workplace" (Gerald A. Kraines), "Psychological Factors in the Prognosis, Prophylaxis, and Treatment of Cancer and Coronary Heart Disease" (Ronald Grossarth-Maticek and H. J. Eysenck), "Cognitive Therapy for Depression" (Robin B. Jarrett and A. John Rush), "Existential Aspects of Psychotherapy" (Hans W. Cohn), "Depression and the Immune System" (Elinor M. Levy and Richard Krueger), "AIDS Dementia" (Balu Kalayam and Charles A. Shamoian), "Co-Dependence: A New Diagnosis" (Robert L. DuPont and John P. McGovern), "Pathological Gambling" (Richard A. McCormick), "Depression and the Elderly" (Michael A. Jenike), "Therapeutic Approaches Toward Clients with a History of Incest in Childhood" (A. Reese Abright) "Anorexia Nervosa, Bulimia Nervosa, and Depression: Multiple Interactions" (Arnold E. Andersen), and "Divorce as a Developmental Catalyst" (Judith H. Gold). Includes an index. (RJM)

ED 398 464

Directions in Mental Health Counseling

VOLUME 2 • TABLE OF CONTENTS

1 ***Stress in the Workplace***
Gerald A. Kraines, MD

2 ***Psychological Factors in the Prognosis, Prophylaxis, and Treatment of Cancer and Coronary Heart Disease***
Ronald Grossarth-Maticek, MD, and H. J. Eysenck, PhD, DSc

3 ***Cognitive Therapy for Depression***
Robin B. Jarrett, PhD, and A. John Rush, MD

4 ***Existential Aspects of Psychotherapy***
Hans W. Cohn, PhD

5 ***Depression and the Immune System***
Elinor M. Levy, PhD, and Richard Krueger, MD

6 ***AIDS Dementia***
Balu Kalayam, MD, and Charles A. Shamoian, MD, PhD

7 ***Co-Dependence: A New Diagnosis***
Robert L. DuPont, MD, and John P. McGovern, MD, ScD, LLD

8 ***Pathological Gambling***
Richard A. McCormick, PhD

9 ***Depression and the Elderly***
Michael A. Jenike, MD

10 ***Therapeutic Approaches Toward Clients with a History of Incest in Childhood***
A. Reese Abright, MD

11 ***Anorexia Nervosa, Bulimia Nervosa, and Depression: Multiple Interactions***
Arnold E. Andersen, MD

12 ***Divorce as a Developmental Catalyst***
Judith H. Gold, MD

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Directions in Mental Health Counseling

VOLUME 2 • LESSON 1

Stress in the Workplace

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VOL. 2, NO. 1

January 1992

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EDITOR'S NOTE

The biopsychosocial model of assessing and treating a wide variety of emotional disorders is generally accepted among clinicians. However, while much attention is paid to intrapsychic dynamics, using appropriate psychopharmacologic treatments, and family function, not much is given to the conditions under which the client works. Yet most of our waking hours are spent working. In this lesson, the author presents several models to evaluate interactions between employees and organizations. These psychodynamic, interpersonal, and adaptational models are familiar to most clinicians, but their application here to work environments is both novel and useful.

Taking a close look at the nature of any client's working conditions and how these may contribute to dysfunctionality—or how they may represent a special asset to aid recovery—should be an essential part of every psychotherapeutic evaluation. Some people may be chronically unhappy for having chosen career paths for which they are not well suited. Others may be caught in transference reactions to superiors and peers. Still others may be involved in working environments inherently destructive to self-esteem.

Aside from client care, clinicians in group practices and those working within institutions have special responsibilities to provide healthy work conditions. Special attention should be paid to those times when organizations change goals or direction, since preparation of employees is critical to successful transition.

Introduction

The mental health field has always maintained a relative distance from the world of work and organizations. **The training mental health care workers undergo ill-prepares them to understand the role that work plays in the development of self-esteem** (Pierce, et al., 1989) **and identity, the nature of the relationship between individuals and organizations, and the dynamic effects of constantly changing work realities on the individuals who must respond to them.**

This lesson will not present a new "psychology of work." Instead, it will summarize the efforts of Harry Levinson (1964, 1976) **and his associates during the past 35 years to adapt existing psychological constructs to work-related interactions.** The clinicians in the Levinson Institute forged these refinements of current psychological theories out in the field—studying, teaching, and serving as consultants to industrial leaders and managers. **The models presented here have proved useful diagnostically, heuristically, for purposes of primary prevention, organizational diagnosis** (Levinson, 1972), **and planning, and for clinical interventions.** The psychotherapeutic approaches offered are biased towards rational-cognitive therapies, which assume people in distress need first to know what they are up against.

Three different models—psychodynamic, interpersonal, and adaptive—are addressed in this lesson to explain the effects of the work environment on human functioning (Levinson, 1976). In each approach, **stress is viewed as a by-product of an individual's frustrated and unsuccessful attempts to achieve or recover a sense of personal equilibrium** (Levinson, 1975). A central task for the clinician

is to examine the client's complaints through each of these lenses in order to see which one offers the most useful information to account for the current "pain" or dysfunction and which models make the most sense to the client. We need to differentiate and identify the various sources of stress in order to understand, predict, and reduce their impact on the client.

Psychodynamic Model

Clinicians need to account for **how and why people make their career and job choices and what motivates people to work hard or to resist working.** By using the psychoanalytic constructs of innate drives, dependency, and ego ideal and self-esteem we can address these issues.

DRIVES:

All personality theories assume the existence of instinctual drive states that propel individuals into the world and govern the degree to which they interact with it. **Psychoanalytic theory with its darwinian origins proposes the basic intrinsic drives are sex and aggression. The vectors of those drives are the constructive energies (love, affection, self-esteem) and the destructive energies (rage, anger, hate). The mature, task-driven individual learns to fuse and harness the energies** from those drives, and the product of their fusion is accomplishment, mastery, and satisfaction (Levinson, 1964, 1981).

People develop defensive strategies (Vaillant, 1986) in order to cope with those innate drives and with their family's and the culture's attitudes about those drives. For example, characterizations of the southern European or Mediterranean culture's

effusive emotionality reflect its open, expansive attitude toward both affection and aggression. By contrast, references to the Anglo-Saxon culture's reserved and modest emotional expression reflect a more repressed, constrained, and sublimating attitude.

In general, people with a predominant need for giving affection—those with a style of nurturing others—may choose careers in nursing or social work. Others geared more toward receiving affection and recognition may choose the performing arts or advertising. Conversely, **individuals with strong aggressive instincts, with powerful needs for control, may choose engineering, accounting, or coaching.** Somewhat **more outwardly aggressive individuals may pursue careers in sales and entrepreneurial endeavors.** Examples of more overtly instrumental or attacking careers are trial law and military drill instruction. The important point is recognition of the predominant drive state in a client's personality and the coping strategies he or she deploys to contend with those drives. Such inferences yield useful information about the context of the person's pain or stress: who is this person and how did he or she get there?

DEPENDENCY:

All creatures at birth are helpless, dependent on others, and forced to come to terms with significant dependence during childhood and adolescence. Conflicts about trust, autonomy, and guilt are inevitable, and resolution of those conflicts determines an individual's subsequent attitudes on dependency and authority relationships and manifest themselves in the world of work. **Healthy adult relationships in organizations require an interdependence that presumes trust in each other's motives and that reduces the guilt of needing support** (Levinson, 1978). **When unresolved conflicts hinder that healthy interdependence, the full continuum**

of defense mechanisms (Vaillant, 1986) may be exhibited in the workplace (especially in the form of projection, displacement, and passive-aggressive and acting-out behaviors). Thus, predictably, we see some transference of parental attributes by the employee onto his or her superior or organization. By projecting those intentions and traits into power figures at work, subordinates then react to them in ways that recapitulate their own nuclear family behavioral patterns. Dynamics such as parental splitting (the white-hat CEO v. the black-hat operations director), scapegoating (blaming the older "rigid" employee for being unable to change), and sibling rivalry (peers competing with each other for recognition) all manifest themselves in organizations.

EGO IDEAL AND SELF-ESTEEM:

The ego ideal refers to the values, qualities, traits, goals, and styles we observed in adults and sought to emulate during our formative years. If we are to feel good about ourselves and avoid feelings of inadequacy and guilt, we feel compelled to live up to that unconsciously internalized prescription of idealized attributes. At any time, our self-esteem is inversely proportional to the size of the gap between our ego ideal and our self-image (Levinson, 1976).

Pursuing one's ego ideal is the most powerful of all motivating human forces, and work is a primary method by which people do so. The process is facilitated when people integrate their own aspirations with those of the organization and their bosses, which occurs through processes of identification and acculturation. On the other hand, if one feels unsuccessful at work, the ego-ideal gap increases and self-esteem plummets. Typically, one then attacks the job and oneself harder to compensate for feeling inadequate. That further devalues one's sense of worth.

The heightened aggression that results may then be redirected toward the self, giving rise to on-the-job accidents, errors, depression, as well as self-defeating behaviors such as alcohol, tobacco, and stimulant abuse. Aggression may be restrained and contained, thus giving rise to the psychophysiological reactions seen with simultaneous "stop-go" commands from the autonomic nervous system, or it may be displaced outward onto substitute tasks or inappropriate targets. **Such compensatory behaviors often occur when an organization shifts its goals and modes of operating without sufficiently preparing its employees. The employees then feel increasingly inadequate, fervently persist in their old ways, and fall further and further behind.**

Work is also a primary forum for meeting one's **affiliative and social needs**, which are important for strengthening self-image. If relationships at work fail to meet a person's needs for affection, respect, and being valued, the gap between one's ego ideal and self-image further widens, yielding even lower self-esteem. Careful psychological studies (Pierce, et al., 1989) confirm the primary determinants of organization-based self-esteem to be managerial respect (affection), organizational structure (providing opportunities for mastery and relationships), and job complexity (allowing for ego-ideal aspirations to be met).

Interpersonal Model

As with purely social relationships, **people are unconsciously attracted to work environments that reflect or complement their own coping styles, offer them opportunities to pursue their ego-ideal requirements, and enhance their self-image and self-esteem.** The nature of the individual-organization bond is

similar to dyadic or family ties in that each partner comes with many elaborate expectations of the other, both conscious and unconscious (Levinson, 1962).

The explicit expectations by the individual of his or her organization often concern concrete issues such as salary and fringe benefits. Conversely, the organization expects an honest day's work, commitment, loyalty, and conformity from the individual.

Less obvious are the implicit expectations individuals have that their organizations will agree to help them live up to their ego ideals. **The individual expects the organization to offer personally meaningful goals for him or her, to be told clearly what is expected, to be assisted in acquiring skills and obtaining resources, and to be protected.** The organization has parallel and reciprocal implicit expectations of its employees. **When those expectations are not fulfilled, the individual experiences the stress or pain of a violated "psychological contract."**

Psychological Contract

The psychological contract, a paradigm developed by Levinson (1962), helps to clarify the different dimensions of this relationship in order to better understand what makes it work, and, conversely, what causes it to be destructive. **The psychological contract asserts there should be a reasonable "fit" between the modes of coping for both the organization and the individual. The degree to which such a fit is lacking determines how much energy both must expend to compensate for the differences. Obviously, this energy is necessarily—yet**

unfortunately—diverted from the central work tasks of the organization and from meeting the individual's own ego-ideal needs. These expectations are implicit, are developed subtly, and are often made explicit only when violated. The three dimensions that best describe these expectations are dependence, distance, and change.

INTERPERSONAL DEPENDENCE:

Dependence refers to how much each "organism" envelops the other and supports the other's existence. The premise is that interdependence is necessary for mature functioning in groups in that it combats the guilt and mistrust experienced when depending on others and it builds toward a common purpose. Each wants the other to succeed, trusting that its own needs will be served as well. Therefore, each wants to create an atmosphere that fosters understanding of and meaningful responses to the legitimate needs of the other. When those conditions are met, both function optimally.

When the legitimate needs of one are denied by the other, feelings of hurt, anger, and abandonment result. Organizations do this when they fail to supervise their employees adequately, follow a "sink-or-swim" philosophy, or cut off opportunities for promotion or training. Similarly, individuals can deny the legitimate needs of their organizations by refusing to accept increased responsibilities.

When either entity exploits the other's dependency needs, stifled feelings of betrayal result, because it is often too dangerous to express anger toward a partner you rely on. Organizations can exploit an individual's dependency

by acting paternalistically and preventing growth and emotional expression. An organization can over-supervise employees, for example, by just giving orders rather than providing the information and guidelines necessary for mastery and advancement. Alternatively, **individuals can exploit an organization by cornering the organization's resources, knowledge, and skills, thereby making themselves indispensable. Individuals may also seek to exploit the organization by consciously or unconsciously failing to develop their peers and subordinates.**

DISTANCE:

Given the interdependence between an individual and an organization, the optimal psychological distance between them is a negotiated product of competing forces of attraction and repulsion.

The forces of attraction between an individual and an organization are the pulls for affection and the needs to control and join their aggressive energies into shared tasks. Thus, an individual seeks to be liked and respected by his or her organization and to have that demonstrated by being given information and resources. The organization expects the individual to work hard toward the organization's goals, to be friendly to people at all levels, and to respect the organization's norms. **In order to meet their shared objectives, the individual expects to be given authority to make decisions and command organizational resources as well as to be rewarded for positive results. The organization expects its employees to accept its needs to retain sufficient control over their work activities to get the job done, to channel aggression into constructive tasks, to temper rivalry, and to play by the rules.**

Forces of repulsion are the needs of each for autonomy and universal, uncontrolled competitive instincts. **The individual expects the organization to respect his or her private life, to not look over his or her shoulder, and to represent him or her well to others. The organization expects the individual to respect trade and management secrets and to refrain from speaking negatively about the organization.**

CHANGE:

Because both the individual and the organization are constantly faced with change demands, the way in which the entire system views change and responds to it is critical to understanding its functioning. **Change involves processes of detachment and reattachment, which require dual tasks: dealing with loss and coping with new demands. The efforts and effects of an individual adjusting to such change may interfere with his or her ability to support the organization's need to change, because an individual's attachments and investments (in roles, relationships, and methods of doing business) are often the basis of his or her identity and self-esteem.** Therefore, an employee's self-esteem may be threatened when the organization demands changes in the usual behaviors. **If individuals and organizations become increasingly rigid, as can occur in the absence of training or preparation for change, their ability to respond successfully is diminished.**

Effective coping with change requires a mutual alliance. Individuals expect the organization not to change their positions without first explaining why it is necessary and by providing alternatives and choices. Furthermore, individuals expect to

be helped to sustain position, role, and standard of living and to be supported by having their psychological "costs" of change acknowledged. The organization expects the individual to change (with restructuring) to meet the organization's needs, even if it is personally costly.

Adaptation Concepts

The third psychological concept with relevance to stress in the workplace is that of the adaptation response. Findings and hypotheses, from Cannon's (1936) "fight-flight" physiologic response to Lindemann's (1944) and Kubler-Ross's (1969) research on the grief response and more-modern concepts like Flach's (1988) resilience hypothesis, **all identify as normal the phases of disruption in human functioning that follow psychological trauma.** Just as the Chinese expression for crisis, ***wey chi,*** means both danger and opportunity, **the process of human adaptation to significant change begins with a critical deterioration of cognition, emotional stability, and behavioral effectiveness. If successfully endured and mastered, that will lead to spontaneous recovery, offering more mature, complex, and resilient functioning later.** Successful and flexible adaptation to change requires a modulation of tension and restraint of the impulse to react prematurely in order to allow enough time to properly scan, analyze, and interpret the problem; to entertain fully any options before deciding on a course of action; to prepare the necessary supplies and support; and to adequately rehearse—all before acting (Solomon, Mikulincer & Hacob, 1987). Thus, the stress or arousal response, if appropriately attended, promotes survival and growth. When the change is positive, it is experienced as stimulating and pleasurable; when it is negative, it is experienced as painful and undesirable.

The sequence of disruption in functioning can be divided into four phases: (a) the initial impact, (b) disorganization (with a focus on loss), (c) recovery (after accepting the reality of loss), and (d) reorganization (when new learning skills are integrated with the old into a new identity). Support must be enlisted for the necessary tasks of grieving the loss and familiarizing oneself with the ensuing new demands and strategies.

Stress Overview

Building on those concepts, we can now view stress as a signal of disequilibrium: a disruption of the usual steady state of competing internal and external forces. The clinician needs to examine stress through several different lenses of human understanding, just as any medical practitioner compares symptoms against each organ system (Andersen, 1989).

When the fundamental imbalance is intrapsychic (i.e., conflicts between the mental structures of the mind: instinctual drives, dependency needs, ego ideal, conscience, and ego), we call the states anxiety, guilt, or fear. This stress is usually chronic and substantially self-inflicted. It derives less from the individual's current job, interpersonal relationships, or state of flux than from chronic feelings of inadequacy, unconsciously perceived danger, and an urgent need to compensate. Such chronic stress is trait dependent. It exists in many different settings for that person and is difficult to alter substantially. **The most crucial work variable affecting this type of internally driven stress is the individual's relationship with his or her superior. Projecting parental (ego-ideal) attributes onto one's boss and then striving for the superior's approval and respect is a powerful compensatory defense mechanism. Failure to gain that recognition may amplify one's self-reproach.**

Conversely, self-indictment may be projected onto one's boss, thereby perceiving disapproval in the absence of other feedback. Traditional psychodynamic therapeutic methods are applicable in treating such chronic stress, but significant relief of fear and helplessness often occurs simply by orienting the client to that frame of reference. By clarifying his or her intrapsychic dilemma and proposing other behavioral options, the clinician can ally with the client's executive ego functions and soften the harshness of his or her ego-ideal indictments.

When the disruption is primarily interpersonal, the concept of a violated psychological contract is useful in diagnosing and treating work-related stress. By examining each dimension (dependence, distance, and change) of the client's relationship with his or her employer, one can often point out the failure to understand or to satisfy each other's expectations. By clarifying the ways in which a particular relationship deviates from the ideal, the appropriateness of the client's expectations—from both the client's and the organization's perspective—can be reconsidered. At the very least, it often becomes clear that the pain has arisen from an unhealthy relationship with unfulfilled expectations, not from any incompetence on the part of the individual. **When the contractual violation is recent, and especially when it is precipitated by organizational change, strategies to assist the client in renegotiating his or her contract can be formulated. However, when the fit between underlying styles and drives has been consistently poor and strained, the stress is usually chronic and probably requires a job change** (Levinson, 1983, 1988).

Most acute or sub-acute work-related stress is a consequence of recent

and significant changes on the job (Lindemann, 1944). They may range from the obvious (being fired, demoted, or transferred) to the more subtle, such as alterations in reporting relationships or in methods of doing business. Various types of support are necessary at different times to help relieve the disruptions in emotions and functioning. The clinician must first rationally help the client to clarify what has happened and then assist the individual in figuring out why. Inevitable feelings of failure and guilt must be acknowledged and countered with appropriate explanations of the crisis process (i.e., that it is normal to feel this way).

During the first few months of critical organizational change, the client must be assisted in developing reduced and realistic personal expectations, because his or her energies and concentration often will be diverted and distracted from the primary tasks at hand. The individual should be encouraged to **clarify the personal and emotional meanings of the changes**, and at the same time begin to **prepare for new ways of functioning.** People also need to be encouraged to mobilize their natural support systems in order to counter their sense of despair and diminished self-esteem.

Even early manifestations of altered emotional functioning have strong implications for one's ability to work effectively. **The "busy-ness" that quickly sets in after significant change is usually unproductive activity geared towards discharging energy and clinging to the familiar.** During those early stages of change, **people must be protected from making poor, impulsive decisions and instead should be encouraged to take time to review what has happened.** The angry protest against reality (normally present for several weeks) needs to be acknowledged and absorbed and aggressive energy freed up to attack the new realities.

If that fails to occur, self-directed anger in the form of guilt and depression can further impair one's energies and divert attention from the tasks at hand. Conversely, **unacknowledged and unresolved anger can give rise to hostile, even paranoid ideation and behaviors that frequently result in attacking the organization rather than allying with it to meet its new demands.** After the sad realization of loss has been acknowledged and comforted, then the useful aspects of one's earlier coping mechanisms must be identified so that they may be retained and incorporated into new styles and skills necessary for successful adaptation.

Such requirements for support may be experienced by the individual as increased dependency needs, which in turn may amplify the individual's feelings of inadequacy, shame, and failure. It is essential to clarify the appropriateness of seeking support during crises and to provide authoritative permission, when necessary. **The client can mobilize many kinds of informal and professional support** in order to facilitate his or her innate resilience: personal expressions of comfort (which ease the sense of alarm); ego support (to facilitate gathering data, finding meaning, and generating options); support for one's identity and self-esteem (by clarifying purpose and worth); faith (to counter feelings of hopelessness); and, occasionally, a selective "taking over" (by giving directions when one is dangerously immobilized).

When the trauma far exceeds the individual's existing coping mechanisms, a predictable decline beyond simple distress can occur. Feelings of entrapment, with associated loss of confidence about recovery, generate only feeble efforts at facing and mastering the tasks at hand. Recovery is still possible with sufficient encouragement and problem-solving support, but it requires a more active

intervention by a clinician. Less reversible are the graver, progressive feelings of despair (feeling no control over one's destiny), apathy, and defeat. **With those forms of "battle fatigue" and "burnout," the clinician's energies must be directed toward rekindling hope, effort, and feeling. Otherwise, the chances of recovering former states of resilience, mastery, and flexibility once in those deeper stages are negligible.**

Diagnostic Process

Accurately locating the sources and meaning of "pain" requires **gathering data and making inferences.** The information needed when clients demonstrate work-related stress is similar to that required for most clinical investigations: **Who is involved? What are the manifest problems, attempted solutions, and current dilemmas? What is the desired outcome?**

The inferences involve locating the pain—that is, who experiences it and/or is the system itself in pain—and then determining its onset (acute or chronic). Those inferences are aided by developing "psychological profiles" of the individuals and the organization (how they handle affection, aggression, and dependency needs, and the nature of their ego ideals), and by evaluating the psychological contract between the individual and the job (how good is the fit; are legitimate dependency needs denied or exploited; does the psychological distance allow for mutual respect, reasonable control and privacy; is systemic change handled fairly and reciprocally). Finally, **during significant organizational change, several factors must be assessed: the degree of perceived control by the individual over the changes; the inherent resilience and flexibility of both the individual and organization; whether the**

expectations of the process and its outcomes are realistic; and the availability of energy, support, and resources in the system and for the individual.

Treatment Process

The old adage that accurate diagnosis is 90% of effective treatment holds true in dealing with stress in the workplace. By employing the diagnostic processes described above, the clinician can reliably pinpoint the areas of greatest distress for the individual. The modes of intervention depend largely on the type of problem and on the style, skills, and orientation of the clinician (Andersen, 1989). However, they begin with a common denominator, namely, **the better one understands what he or she actually faces, the greater the sense of personal control and subsequently the greater the ability to focus energies on influencing reality and improving the behavioral effectiveness.**

Thus, explicit and simple explanations by the clinician of his or her formulation for the client should be the starting point for all interventions that follow.

Examples

Two case studies illustrate typical situations involving work-related stress.

CHRONIC STRESS: INTRAPSYCHIC PROBLEMS ADDRESSED BY CHANGING ONE'S PSYCHOLOGICAL CONTRACT:

M.P., **a 52-year-old male married high school principal**, was referred by his superior because of **increasing depression and migraine symptoms. Once the client's endogenous components were treated pharmacologically, his life-**

long patterns of perfectionistic strivings, need for approval, and aversion to conflict re-emerged and he then resumed his powerful self-imposed pressures. He felt he had to simultaneously resolve all conflicts and satisfy all needs of students, faculty, administration, and community. Although he was extremely intelligent, effective, and widely admired, he soon felt helplessly entrapped and his migraines again worsened.

Once the psychodynamics were understood (i.e., harshly demanding ego ideal, powerful reaction formation, etc.) and the rigidity of his defenses was clarified, **the vicious cycle was explained to the client and (with his permission) to his boss. They were encouraged to develop very clear guidelines to limit M.P.'s responsibilities and efforts to only those necessary for his executive role; the remaining duties were explicitly delegated. M.P. and his boss contracted to meet regularly to review his work style** and reinforce his value as a resource and friend. Psychotherapy (limited by the client's alexithymia) focused on grieving the loss of freedom to tackle all of the problems and establish a competing ego ideal, valuing a more balanced lifestyle.

VIOLATED PSYCHOLOGICAL CONTRACT SECONDARY TO SIGNIFICANT ORGANIZATIONAL CHANGE:

R.D., **a married 42-year-old male administrator of a community hospital's clinical service**, was referred by his family doctor with **panic attacks of recent onset and mixed anxiety/depressive symptoms.** He was a bright, confident, and conscientious manager—strongly analytical and also proud of his ability to treat his staff fairly and respectfully. **During the previous year, the hospital in which he worked changed administrators**—in part because of the increasingly competitive

health-care environment. That was part of a deliberate shift in philosophy from being committed primarily to quality and serving people (which was my client's shared value system with the hospital) to becoming far more aggressive, cost-cutting, and market-oriented. His ability to sustain his department's technical quality and his staff's morale diminished quickly. He felt himself becoming a failure and was unable to argue persuasively with senior management for his department's needs. His frustration and anger were amplified by thinking he was now "losing it."

Once the anxiety/depressive symptoms were contained with medications, the client was helped to see how his psychological contract was unilaterally changed by the hospital and that their respective value systems were now frequently in conflict. He was then guided in a decision-making process through which he realized he was not prepared to change jobs and move in the near future. That freed him to shift from a caretaking/protective managerial posture toward one of helping to prepare his staff to understand and deal with the new realities and to help them find new ways to support themselves within the organization. He was then able to reduce his emotional investment in his hospital identity and shift his creative energies toward coaching and sports activities outside of work. Finally, he was helped to grieve the loss of "the good old days" and to view the work changes as more sad than evil.

Prevention

Preventing mental or behavioral problems from arising in any organization requires an understanding of the intrinsic strengths and vulnerabilities of that ecosystem and

the forces that threaten its equilibrium. **Primary prevention involves reducing, eliminating, or preventing such noxious destabilizing forces and enhancing the adaptive capabilities of the entire system** (Caplan, 1964).

Organizational consulting firms, such as the Levinson Institute, translate clinical principles into useful paradigms and seminars for executives who must lead and engineer changes in their organizations. These industry leaders recognize that it is simply "good business" to create atmospheres that encourage their employees to be successful and productive. They may also proactively employ clinically-based consultation when their companies anticipate making significant changes in order to best prepare for the types of support their employees will need and to facilitate the subsequent renegotiation of psychological contracts. For any plan to be successfully implemented, it must not only be technically sound, but it must also be accepted and "owned" by the very employees who must implement it.

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QUESTIONS BASED ON THIS LESSON:

1. Which of the following models is not presented by the author as a framework for understanding the relationship between work environments and human health and behavior?

   A. Psychodynamic

   B. Biopsychosocial

   C. Interpersonal

   D. Adaptive

2. Which of the following statements is correct?

   A. People with a need to give affection are mostly likely to seek careers in electrical engineering

   B. Individuals with strong aggressive drives commonly choose careers in teaching and health care

   C. Transference of parental attitudes onto superiors at work rarely, if ever, occurs

   D. When organizations shift goals without sufficiently preparing employees, employees often feel inadequate and persist in outmoded ways of behavior

3. Which of the following statements is correct?

   A. Interdependence and trust are unnecessary for mature functioning in groups when power is concentrated in a few hands

B. The individual who fails to develop peers and subordinates is behaving exploitively, violating the psychological contract between the individual and the organization

C. The "distance" dimension of the employer-employee psychological contract simply provides for adequate vacation time

D. Organizational changes rarely induce stress among employees and little preparation for change is required

4. In the management of work-related emotional distress, clinicians can best:

A. Help the individual regain self-control by identifying the real issues and events involved

B. Always direct the individual to seek a job elsewhere

C. Reveal the individual's private feelings to his or her employer without permission

D. Presume the problems are entirely intrapsychic and that if the individual undergoes psychotherapy he or she will be able to remain healthy in any working environment

Directions in Mental Health Counseling

VOLUME 2 • LESSON 2

Psychological Factors in the Prognosis, Prophylaxis, and Treatment of Cancer and Coronary Heart Disease

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VOL. 2, NO. 2

February 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

Professors Eysenck and Grossarth-Maticek have carried out highly original and provocative studies of the relationship between personality type and the risk of developing cancer or coronary heart disease. Since their conclusions are based on prospective studies, they are especially powerful.

Essentially, they have identified four basic types. Type 1 is cancer prone; personality traits include a strong need to be close to some emotionally important person or achieve an important goal, although the object has withdrawn permanently or the goal is unattainable. Concealed depression and hopelessness ensue.

Type 2 is prone to heart infarct/stroke mortality and is characterized by the need to gain distance from a disturbing object, which cannot be accomplished. The object is viewed as the cause of all the individual's problems. Permanent irritation, anger, helplessness, and a feeling of subjugation are present.

Type 3 is particularly interesting, since it is associated with an average or elevated survival rate and seems to be a significantly less tightly organized personality structure. This type is ambivalent toward emotionally important objects, perceives and sends inconsistent messages, swings between closeness and distance in relationships, and experiences anxiety and aggression toward self and others.

Those in Type 4 have elevated survival rates and are characterized by object independence and autonomy, the ability to integrate opposite emotions and successfully express them, affection for self and others, the ability to learn from experience, and a high level of self-esteem and confidence.

Not only have these personality types been identified, but controlled studies have shown that psychotherapy, behavioral therapy, group therapy, and self-instruction

aimed at modifying vulnerable personality traits can prolong life in those who are already ill and prevent illness for years in those who might otherwise have succumbed.

Introduction

Modern medicine has concentrated on specific physical and behavioral characteristics, including cigarette smoking and diet, as being prognostic of cancer and coronary heart disease and constituting the major areas of intervention for prophylaxis and treatment. Eysenck (1987*a*, 1987*b*, 1988*a*) has found the physical and behavioral factors to be of only minor importance, whereas social factors, such as personality and stress, may be of greater significance (Grossarth-Maticek, Eysenck & Vetter, 1988). The psychosomatic approach to explaining the presence of disease is not entirely new (Lipowski, 1984). Even though such an approach can be traced back to the ancient Greeks, it had a hard fight to gain acceptance by the modern medical community. **Most notable has been advocacy for the theory of type A–type B behavior** (Rosenman & Chesney, 1980), **but that concept has been shown to be of rather dubious value.** A metaanalysis of all available prognostic studies carried out by Mathews (1988), which took into account the number of cases involved, found a *P* value of .261—completely insignificant—although one-tailed tests were used. A somewhat more hopeful picture emerges when separate analyses are made between methods of assessment: standardized interview techniques give somewhat positive results, whereas questionnaire studies do not. Similarly, a distinction must be made between population-based studies and those of high-risk groups. Population-based studies yield the only positive results (Eysenck, in press). Those generalizations are supported by large-scale reviews by Booth-Kewley (1987) and Friedman (1987), as is the belief that **only certain aspects of type A behavior—in particular anger, aggression, and hostility—are relevant to the prediction of coronary heart disease** (Krantz & Manuck, 1984).

As regards cancer, the view that certain personality types are cancer prone goes back at least as far as Hippocrates and his followers, who spoke of melancholia constituting the essential personality feature to antedate cancer. Many medical observers have since suggested a variety of traits as characteristic of the cancer-prone personality, including being overly cooperative, appeasing, and unassertive. A person with a cancer-prone personality avoids conflict, is compliant with external authority, suppresses emotions such as anxiety and anger, and has difficulties in coping with interpersonal stress, which leads to feelings of helplessness, hopelessness, and depression. That cancer-prone personality type has recently been designated "type C" (Baltrusch, Stangel & Waltz, 1988). The whole concept of the disease-prone personality has been examined by Friedman and Booth-Kewley (1987), who conclude evidence is sufficient for a major undertaking of psychological research into the prevention and treatment of disease. A detailed argument for the holistic approach to medicine can be found in Pena (1983).

Early evidence of the relationship between personality and disease has been reviewed by Eysenck (1985). Here we shall examine some recent studies that built on those established relationships to identify persons prone to cancer and coronary heart disease (CHD) and who have proceeded to adopt the principles of behavior therapy to change behavior patterns toward a healthier personality type (Eysenck, 1988*b*; Grossarth-Maticek, Eysenck & Vetter, 1988, Grossarth-Maticek et al., 1988).

In the three studies to be summarized here, participants were selected on a semirandom basis, with parameters for age and sex, and were administered a personality inventory that embodied theories concerning cancer-prone and CHD-prone personality. They were then followed up over a period of at least 10 years until death, when the cause of death was ascertained. Altogether, probands were labeled as one of

the following four types on the basis of a questionnaire and interviews.

Type 1 has an increased risk of cancer mortality. Such persons manifest **strong needs to be close to another emotionally, or to pursue and achieve some highly valued goal. However, the object of their need or pursuit has permanently withdrawn.** It is unattainable. But in spite of this, the person still views it as essential to his or her well-being. Any efforts to find a replacement for it or to disengage emotionally from the bond have failed and continue to fail. In a persistent way, the person idealizes the object and diminishes his or her own worth. **The result is helplessness, hopelessness, and depression, and even a desire to die.** Yet the personality structure is such that the individual so affected tries to hide these feelings, even from himself or herself and rules out suicide for a variety of moral or ethical reasons.

Type 2 has an increased risk of heart infarct/stroke mortality. Such persons shows **a powerful need to distance themselves from a disturbing person or object. Yet they cannot,** continuing to view it as the primary source of difficulty and distress. All efforts to disengage or change the object have been unsuccessful, and the person or object in question continues to be perceived in a one-sided, entirely negative manner. **The result is ongoing irritation and anger, helplessness,** a feeling of being enslaved in the dilemma, and even **a desire to die** that is not translated into suicidal acts because of moral or ethical responsibilites.

Type 3 has an average or even elevated survival rate. Such individuals are **ambivalent toward emotionally valued objects and persons, perceiving and sending mutually inconsistent messages.** Closeness is desired, yet feared, and efforts at closeness fluctuate with distancing in quick succession. Dependency on the

person or object toward whom the individual feels ambivalent is ongoing and strong, and the result of this is anxiety and aggression, the latter expressed toward the self as well as others.

Type 4 has an increased survival rate. Such individuals possess independence and autonomy and accept the right of others to be the same way. Opposite emotions such as love and anger can be managed in an integrated way and they are clearly expressed. Affection is felt toward self and others. Such persons learn from experience and as a consequence grow in knowledge and emotional maturity. Self-confidence is present and when anything occurs to compromise self-esteem, the ability to regain it is there. They can effectively regulate interpersonal closeness and distance, reflect a general sense of well-being and satisfaction, maintain a reasonable level of activity, and minimize loyalty conflicts and ambivalent interactions.

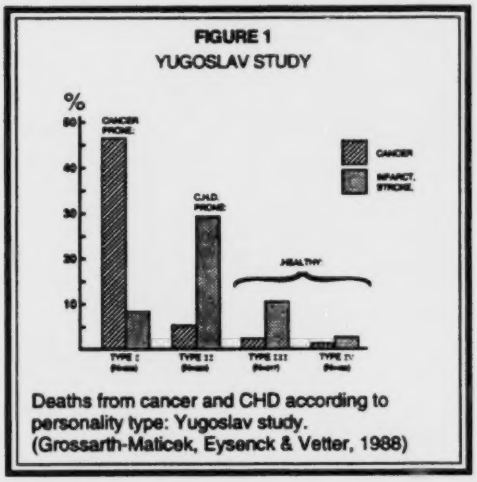
Further study details, with the questionnaire used, are included in a paper by Grossarth-Maticek, Eysenck, and Vetter (1988).

Study Populations

The first sample, collected in Yugoslavia, is a random one of mainly elderly people. The second, collected in Heidelberg, Germany, constitutes a normal sample that was rather younger than the Yugoslav one and selected along quota lines. The third sample comprised persons who were nominated as suffering from marked interpersonal stress, with the nominations being taken from members of the second sample. The Heidelberg "stressed" sample is similar in age and sex composition to the Heidelberg "normal" sample, the only difference being the incidence of stress. Distinguishing stressed from normal enabled us to study the importance of stress as far as mortality from

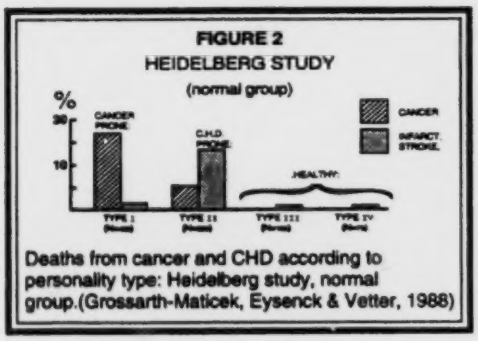
cancer, coronary heart disease, and other causes is concerned.

Study Results

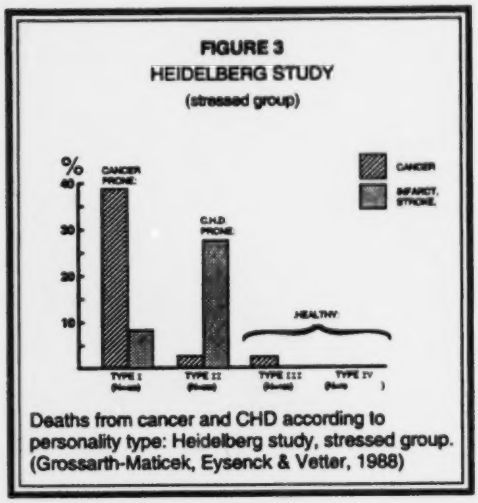


Deaths from cancer and CHD according to personality type: Yugoslav study. (Grossarth-Maticek, Eysenck & Vetter, 1988)

Figures 1, 2, and 3 show in graphic form the results of the studies as well as the number of cases involved. **They reveal a clear-cut statistical relationship between personality and disease. Type 1 persons die much more readily of cancer than of coronary heart disease, whereas type 2 persons die much more frequently from coronary heart disease than from cancer. Persons of types 3 and 4, as expected, are relatively immune to both major causes of death in modern civilization.** The percentage of deaths is greater in the Yugoslav sample because the participants were older, and they are greater in the Heidelberg "stressed" group because of the criteria used to select group members. As expected, the sample having the lowest death rate is the "normal" Heidelberg sample. The results clearly show personality can predict with considerable accuracy



Deaths from cancer and CHD according to personality type: Heidelberg study, normal group.(Grossarth-Maticek, Eysenck & Vetter, 1988)



Deaths from cancer and CHD according to personality type: Heidelberg study, stressed group. (Grossarth-Maticek, Eysenck & Vetter, 1988)

the likelihood of a person dying of cancer or coronary heart disease. It is noteworthy that the studies reveal much higher predictability based on the inventories used than was possible with the type A–type B predictors. Prediction based on physical causes such as smoking and high cholesterol levels was much less successful than predictions based on personality factors.

A comparison of the relative influence of physical factors with personality revealed personality to be approximately six times as important as physical factors as a whole. Smoking, in particular, was found to be positively correlated with disease only in those who were cancer prone or CHD prone by personality. No correlation was found for types 3 and 4. In other words, a synergistic relationship between personality and physical factors like smoking is evident.

Intervention Studies

Those results are, of course, entirely correlational: they suggest, but do not prove, the existence of a causal relationship between personality and disease. To make a causal relationship more likely, we carried out several intervention studies in which we attempted to use the principles of behavior therapy to alter the behavior of types 1 and 2 in the direction of type 4—greater autonomy; a less repressed

attitude towards emotional expression; and, most of all, the adoption of coping mechanisms to deal with the interpersonal stress so prominent in persons of types 1 and 2 (Grossarth-Maticek & Eysenck, 1991*a*).

The general scheme followed in the three intervention studies to be described was always the same. Study participants did not suffer from cancer, heart disease, or any other debilitating illness. Only persons of type 1 or type 2 were included, and they were assigned on a random basis to either a control or a treatment group. They were then followed up for varying periods. Upon death, the cause was ascertained from the death certificate. The randomization process ensured the applicability of the normal tests of significance and at the same time equalized the influence of other factors, such as smoking and medication.

Individual Treatment Study

In the first study, we used an individual treatment procedure lasting a total of 25 to 30 hours and delivered at the beginning of the follow-up period. Although 30%–40% refused, all those who entered treatment completed it. The study population comprised 100 cancer-prone probands and 92 CHD-prone probands, who were assigned to either a control or a therapy group. Group membership was decided on the basis of a randomization procedure. Probands were followed up for a period of 13 years (see Table 1). **The method of behavior therapy used was highly effective in preventing both cancer and coronary heart disease.** Clearly, long-term, individual behavior therapy can be effective as a prophylactic means of preventing cancer in cancer-prone probands and coronary heart disease in CHD-prone probands.

TABLE 1
Effect of Prophylactic Behavior Therapy on Cancer-Prone and CHD-Prone Probands in Heidelberg Stressed Sample (Grossarth-Maticek, Eysenck & Vetter, 1988)

Risk: Cancer	Alive	Deceased from Other Cause	Deceased from Cancer	Total
Control group	19	15	16	50
Therapy group	45	5	0	50
Total	64	20	16	100

Risk: Infarct/Stroke	Alive	Deceased from Other Cause	Deceased from Infarct/ Stroke	Total
Control group	17	13	16	46
Therapy group	37	6	3	46
Total	54	19	19	92

Group Therapy Study

The second study was designed to examine the effectiveness of group therapy, applying the same principles as in the previous study to groups of about 20 probands. The groups met a number of times, for a total of 6 to 30 hours, depending on the wishes of the group. The therapy group and the control group each had 245 randomly assigned probands of type 1 or type 2. Table 2 reveals **group therapy was highly effective in preventing death from cancer or coronary heart disease in the therapy group, as compared with the control group.** The follow-up period was eight years.

TABLE 2
Deaths from Cancer and Other Causes in Control and Therapy Subjects: Group Therapy (Eysenck, 1988*b*)

	Therapy Group	Control Group
"N"	245	245
Untraceable	6	11
Follow-up group	239	234
Deaths	48	180
Died of:		
Cancer	18	111
CHD	10	36
Other Causes	20	33
Still living	191	56

Individual Therapy with Self Study

In the third prophylactic study, we used **brief individual therapy along with a printed leaflet that set out aims and methods of treatment and was given to the probands to keep and read repeatedly. The one-hour treatment was administered by students who had been taught the principles of behavior therapy as it applies to physical disease.** The therapy group numbered 600; the control group, 500; and the placebo group, 100. Members of the placebo group received "dynamic" type therapy and a leaflet that outlined the principles of dynamic psychotherapy as applied to physical disease. Placebo treatment was introduced to see if simply interacting with probands might have a beneficial effect. Table 3 outlines the results. **Based on those results, therapy has been shown to have profound positive effect relative to placebo treatment,** which was no better than the complete absence of treatment in the control group. No detailed probability statistics are given for three studies, as all were well below the .001 level. The follow-up period in the third study was 10 years.

TABLE 3
Deaths from Cancer and Other Causes
in Control, Placebo, and Therapy Subjects:
Short Individual Therapy

	Died of Cancer		Died of CHD		Other Causes of Death		Total Deaths		Still Living	
	No.	%	No.	%	No.	%	No.	%	No.	%
Group:										
1 - Control (N=500)	106	21	145	29	164	33	415	83	78	16
2 - Placebo (N=100)	22	22	31	31	28	28	81	81	19	19
3 - Therapy (N=500)	27	4	47	8	115	19	189	32	409	68

(Seven persons in Group 1 and two in Group 3 could not be traced.)

Prolonging Life Through Behavior Therapy

All three studies discussed above focused on prophylaxis; i.e., the prevention of cancer and coronary heart disease through appropriate methods of behavior therapy. **Is it possible to apply behavior therapy to a person suffering from an incurable disease in an attempt to prolong life? Two studies we have carried out suggest it to be so.** In the first, we formed 24 pairs of patients who suffered from similar types of cancer, had similar treatment, and had similar life expectancies. One person in each pair was randomly assigned to a treatment group, the other to a control group, and the survival time was ascertained for all patients. Results are shown in Table 4. **The total survival time of the treatment group was 5.07 years, whereas that of the control group was 3.09 years**--a statistically significant difference.

In yet another study we looked at the survival time of 100 women suffering from terminal cancer. The study participants were selected from a larger group of

TABLE 4
Survival of Treated and Untreated Cancer Patients

Type of Cancer	No. of Pairs of Patients	Survival Time, Years: Therapy Group	Survival Time, Years: Control Group
Scrotal	1	5.8	3.2 +
Stomach	1	4.8	1.8 +
	2	2.4	2.3 +
Bronchiolar	1	1.7	2.4 -
	2	5.6	1.5 +
	3	4.2	1.6 +
	4	3.2	1.1 +
	5	1.7	1.7 =
	6	4.5	1.2 +
	7	5.2	1.0 +
Uterine	1	6.8	4.2 +
	2	4.5	4.8 -
	3	7.2	3.5 +
	4	8.2	3.1 +
Cervical	1	5.5	4.2 +
	2	6.1	4.0 +
	3	3.2	3.3 -
	4	4.5	4.1 +
	5	2.8	3.6 -
Colorectal	1	9.5	4.2 +
	2	7.5	2.1 +
	3	6.3	4.9 +
	4	4.8	4.3 +
	5	5.7	4.1 +
TOTAL:	24	5.07	3.09

+ longer survival time for therapy group member
- shorter survival time for therapy group member
= equal survival time for therapy group and control group members

women, enabling us to obtain equal numbers for each of the four cells of the research design. Half had elected to undergo chemotherapy, and half had rejected it. Behavior therapy was offered to, and accepted by, 25 women in each of the two groups; no behavior therapy was offered to the remainder. We thus had four numerically equal groups receiving no therapy, chemotherapy plus psychotherapy, chemotherapy

only, or psychotherapy only. The average survival time was 11.28 months for the group receiving no therapy, 14.08 months for those receiving chemotherapy only, and 14.92 months for those receiving psychotherapy only. **Those receiving both types of therapy survived 22.40 months.** The difference between chemotherapy only and psychotherapy only was not significant, but both were significantly better than no therapy. Combined therapy was significantly better than either therapy alone and showed a significant synergistic effect. The two therapies together produced a length of survival significantly higher than that due to their separate effects (Eysenck, 1988*b*).

Conclusion

Although we have concentrated on our own work in this lesson, a large body of literature now suggests personality and stress do play an important part in disease, and psychological methods of treatment, notably behavior therapy, may have a profound prophylactic effect—even to the point of prolonging life in terminally ill patients. **Theories have been developed to account for that relationship, notably involving the immune system, but evidence is insufficient to support any of them.** Most needed at the moment is a replication of the studies here summarized that also undertake immunassays of control and therapy groups. Clearly, the subject matter is one ideally suited for interdisciplinary study, with involvement of oncologists, experts on diseases of the heart and circulation, epidemiologists, immunologists, and psychologists. It is well known that interdisciplinary studies are particularly difficult to arrange and carry out, but the need is obvious and the rewards are large. What cannot be doubted any longer, however, is the importance of psychological factors, such as personality and stress, in the genesis and progress of physical diseases like cancer and coronary heart disease. The recognition of that fact is essential for further advances in prophylaxis and treatment.

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SUGGESTED READING

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QUESTIONS BASED ON THIS LESSON:

5. Which of the following statements is correct?

   A. All features of type A behavior are relevant to susceptibility to coronary heart disease except anger, aggression, and hostility

   B. Hippocrates and his followers spoke of persistent euphoria as antedating cancer

   C. All studies linking personality with physical illness have been done retrospectively

   D. Prediction of cancer and coronary heart disease appears to be higher based on personality factors than on such physical contributants as smoking and high cholesterol

6. Type 2 personality, with increased heart infarct/stroke mortality, is characterized by:

   A. A strong need to distance from a disturbing object which cannot be accomplished, leading to permanent irritation, anger, and a sense of helplessness and subjugation

   B. Maladjusted, unexpected behavior to satisfy extreme wishes for, as well as fear of, closeness and distance

   C. Successful integration of seemingly opposite emotions

   D. Object independence and autonomy

7. Which of the following statements is correct?

A. Only behavior therapy is effective in reducing the risk of cancer or heart disease

B. Only individual therapy with self-study is effective in reducing the risk of cancer or heart disease

C. In a controlled study, behavior therapy actually shortened the life span of cancer patients

D. All three forms of therapy—group, individual, and behavioral—reduced the risk of cancer and heart disease, and combining chemotherapy with psychotherapy has been shown to prolong the life span of patients with terminal cancer.

8. Which of the following statements is correct?

A. The relationships seen between personality and proneness to illness are not correlational, but establish a causal connection between the two

B. Behavior therapy has been shown effective in preventing both cancer and coronary heart disease

C. Types 1 and 2 should be encouraged in therapy to become more dependent and repress emotional expression

D. Group therapy is not useful in changing attitudes so as to reduce the risk of cancer and coronary heart disease.

Directions in Mental Health Counseling

VOLUME 2 • LESSON 3

Cognitive Therapy for Depression

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VOL. 2, NO. 3

March 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

Cognitive therapy has received a good deal of attention as one psychotherapeutic approach to the treatment of depression. It is a highly structured approach that seems to permit rapid improvement from depression and may reduce the chance of relapse/recurrence.

Cognitive therapy is based on the hypothesis that depression results from faulty perception and cognition. Depressed patients hold negative views about themselves, their worlds, and their futures. Unarticulated rules influence their emotional, behavioral, and thinking patterns. Logical errors—perhaps better rephrased as errors of logic—are exemplified when a depressed person draws conclusions not supported by data, generalizes from isolated incidents, or exaggerates or diminishes the importance of certain events.

Therapy attacks these false concepts. Once rapport has been established, the therapist uses questioning to encourage the patient to test the objectivity or validity of specific thoughts or ideas. The rationale for treatment is emphasized to organize the patient's approach to it. Patients are encouraged to monitor themselves in a variety of stress-provoking situations, reexamine premises, gain distance from automatic assumptions and the adverse emotions accompanying them, and view their perceptions as hypotheses subject to testing. The usual course of therapy consists of two individual sessions a week for 10 weeks.

Why cognitive therapy works remains unclear. Is it a way to restore morale? Is the effort to undermine misleading conceptions central to its effect? Perhaps one key factor is offering the helpless, confused, out-of-control depressed patients a systematic structure to restore command over themselves and their environment.

Introduction

Cognitive therapy is a short-term psychosocial intervention designed both to ameliorate the symptoms of nonpsychotic, unipolar depression (i.e., it is designed for symptom reduction) and to decrease the probability that depression will recur (i.e., it is designed for prophylaxis). This lesson describes briefly the cognitive model of depression, the typical course of cognitive therapy, and the evidence for its effectiveness.

The Cognitive Model

THE PREMISE OF THE COGNITIVE MODEL:

The premise of the cognitive model is that cognitions (images and thoughts) influence emotions and behaviors. This premise is grounded in a phenomenological approach to psychology, a perspective which assumes that **behavior is influenced by the individual's perception of himself or herself and of the world.** According to the cognitive model, the central feature of depression is a group of distorted cognitions. Therefore, within the cognitive model, other symptoms typical of depression, e.g., motivational deficits, suicidal impulses, and sadness, are augmented by distorted thinking patterns.

COGNITIVE THERAPY'S UNIT OF FOCUS— DISTORTED COGNITIONS:

Rush (1983*a*) has defined cognitions as images and thoughts or "what a person thinks to himself in a situation." According to the cognitive model, cognitions are important because they are related to the feelings and behavior which occur in the situation. Beck (1963) maintained that the **cognitions associated with depression are automatic, involuntary, plausible, persistent, and often contain a theme of loss.** Beck

distinguished between socially accepted or objective definitions of particular events (e.g., loss) and private meanings of events (i.e., the significance of the event to the individual). He stressed that it is the private interpretation of events that is critical to the emotional responses that follow these events. The emphasis on the private meanings of events reflects the roots of cognitive therapy in phenomenological conceptualization of psychopathology. However, it is also the disparity between private and public meanings of events that result in discrimination between "distorted" and "rational" cognitions.

In describing and theorizing about depression, Beck (1967,1972,1976) identified three elements deemed essential to the psychopathology of depression. These are the cognitive triad, silent assumptions, and logical errors.

TABLE 1
Examples of Cognitions from the Automatic Thoughts Questionnaire*

I feel like I'm up against the world.
I'm no good.
Why can't I ever succeed?
No one understands me.
I've let people down.
I don't think I can go on.
I wish I were a better person.
I'm so weak.
My life's not going the way I want it to.
I'm so disappointed in myself.
Nothing feels good any more.
I can't stand this any more.
I can't get started.

* From Hollon, S.D., Kendall, P.C. (1980). Cognitive self-statements in depression: Development of an automatic thoughts questionnaire. *Cognitive Therapy Research, 4,* 383-395.

COGNITIVE TRIAD:

The cognitive triad consists of the negative views held by depressives about themselves, their world, and their future (Table 1). Generally, depressives assume that they, their world, and their future lack some feature(s) that are a prerequisite for happiness. For example, depressives may view themselves as unworthy, inadequate, or

incompetent. They may view their environment as continually demanding and unsupporting. They may describe the future as hopeless and predict that their deficits and current pain will continue indefinitely. These negative views, the cognitive triad, account for, maintain, or contribute to other symptoms commonly found in the depressive syndrome. That is, if depressives think that "today will be just as miserable as yesterday," then they will feel and behave as if this thought were literally true or valid; for example, they will feel sad and stay in bed. These negative views are called automatic thoughts and they are found in the stream of consciousness of the depressive in specific situations.

SILENT ASSUMPTIONS:

The second element found in the psychopathology of depression consists of silent assumptions or rules. These are **unarticulated rules that influence the depressive's emotional, behavioral, and thinking patterns** (Table 2). Silent assumptions are psychological constructs on which the patient bases his or her emotional and behavioral responses on them. **For example, the depressive may believe, "If I am not loved by everyone, I'm unworthy." These stable beliefs develop from early experience and subsequently influence the individual's**

TABLE 2
Sample Items from Dysfunctional Attitudes Scale*

It is difficult to be happy unless one is good looking, intelligent, rich, and creative.

Happiness is more a matter of my attitude toward myself than the way other people feel about me.

People will probably think less of me if I make a mistake.

If I do not do well all the time, people will not respect me.

Taking even a small risk is foolish because the loss is likely to be a disaster.

It is possible to gain another person's respect without being especially talented at anything.

I cannot be happy unless most people I know admire me.

If a person asks for help, it is a sign of weakness.

*From Weissman, A.W. (1979). The Dysfunctional Attitudes Scale: A validation study. Dissertation Abstracts International, 40, 1389-1390B.

responses to events. According to the cognitive model, these silent assumptions give rise to automatic thoughts. Silent assumptions are typically stated as "if-then" premises that can be identified by examining patterns within a group of automatic thoughts or behavioral responses.

Depressive assumptions are typically inferred by examining the situation, emotions, and themes associated with the array of negative automatic thoughts. For example, a depressed woman may report sadness when her spouse does not compliment her on her appearance. She may report thinking, "He is not attracted to me anymore because I am ugly." She may also report feeling dysphoric when a friend talks to her for only five minutes in the grocery store. She may report thinking, "She would want to spend more time with me if I weren't so dull." Through repeated examples and verbal exchange, the therapist and patient may infer the silent assumption, "If others don't attend to me, it's (a) something to be disturbed about and (b) because of a deficit I have."

The cognitive model posits that these inappropriate assumptions are activated more frequently than appropriate (undistorted) assumptions when a person is depressed. It is assumed that as the depression becomes more severe, the individual's thinking becomes more disparate despite logical or objective evidence to the contrary.

LOGICAL ERRORS:

The third element essential to this cognitive model are the logical errors spawned by the negative automatic thoughts made by the depressive. Logical errors are identified by examining logical relationships between a specific event and the associated negative

automatic thought. Some examples of logical errors include arbitrary inference, selective attention, overgeneralization, magnification or minimization, and personalization. Arbitrary inference occurs when the depressed person draws conclusions that are not supported by logical or environmental data. Selective attention refers to emphasizing certain details and ignoring others. Overgeneralization includes drawing conclusions about one's ability, performance, or worth based on a single incident. Magnification or minimization refers to exaggerating or diminishing, respectively, the importance of an event. Personalization involves associating events with oneself when logic or data would prohibit such associations.

THE VULNERABILITY FOR AND MAINTENANCE OF DEPRESSION:

According to Beck and Greenberg (1976), the existence of silent assumptions increases an individual's vulnerability or predisposition to depression. These assumptions may develop through interactions with significant others. In particular, depressive assumptions are learned in the context of "an unfavorable life situation," e.g., the loss of a parent or chronic rejection by peers. Later in life, when the individual is exposed to a situation analogous to the original unfavorable life situation, he or she employs the previously learned assumptions.

Once activated, these schemata or assumptions are applied to an ever-widening array of stimulus situations and thereby lead to more negative automatic thinking. For example, a person who is overly concerned with approval from others may view normal day-to-day transactions as if they meant he or she is not liked by anyone, e.g., the flight attendant on the airplane didn't smile. That means, "no one likes me."

The typical emotional, motivational, behavioral, and vegetative depressive symptoms (e.g., hopelessness, apathy, agitation and sleep disturbance) are made worse by this negative automatic thinking. As depressive symptoms worsen, the distorted thinking increases. Beck has termed the relationship between depressive symptoms and thoughts a "vicious cycle," a "circular feed-back model," and the "downward spiral of depression."

The Typical Course of Cognitive Therapy

ESTABLISHING A THERAPEUTIC ALLIANCE AND RATIONALE:

One of the first steps in cognitive therapy involves developing a rapport with the patient, and establishing a "collaborative alliance." The therapist's role in this alliance is to guide the patient. For example, each session begins with the therapist and patient listing and prioritizing items on the "agenda" to be covered. The competent cognitive therapist not only has refined general psychotherapeutic skills (i.e., he or she is perceived as warm, genuine, empathic, and able to understand and reflect the patient's thinking), but also can remain objective and logical about the automatic thoughts and emotional responses which are identified. **The therapist usually phrases most comments as questions, to be answered by the patient, rather than as statements.** The cognitive therapist typically **avoids attempting to "persuade"** the patient that his or her thoughts are dysfunctional. Instead, the therapist **encourages the patient to test the objectivity or validity of specific thoughts or ideas** by examining their inherent logic and/or by seeking supportive or discomfirming data within the patient's daily life. Such an alliance has been labeled "collaborative empiricism" (Beck et al., 1979).

The therapeutic alliance is of special importance when working with depressives, who characteristically overpersonalize and are likely to respond negatively to neutral or even

positive interpersonal interactions. When problems occur within the therapeutic context (e.g., relationship difficulties, missed appointments), these problems are conceptualized within the cognitive model. That is, corresponding thoughts and emotions are identified and problem-solving strategies are implemented. For example, a depressive may report missing a therapy session after thinking, "I've been depressed before and received therapy. I'm depressed again so this won't work either." The therapist can consider the report of these thoughts as an opportunity to review the (a) similarities and dissimilarities of past and current therapies, (b) evidence supporting or refuting the notion that cognitive therapy will not work, (c) advantages and disadvantages of cognitive therapy to date, and (d) changes that may need to be made in the therapy.

To foster a collaborative alliance, much time is devoted to providing a rationale for treatment. The verbal rationale may be supplemented by asking the patient to read Beck and Greenberg's *Coping With Depression* (1976). This pamphlet aids in "socializing" the patient to cognitive therapy by (a) describing many of the depressive symptoms from which the patient may suffer, (b) illustrating dysfunctional thinking, (c) focusing on the relationship between dysfunctional thinking and depression, and (d) encouraging the patient that his or her problems can be alleviated by learning to recognize negative thoughts, testing the validity of the thoughts, and problem solving.

Processes and Techniques of Cognitive Therapy

SELF-MONITORING:

Self-monitoring is used to aid the patient in identifying thoughts which accompany uncomfortable emotions and difficult situations. By completing the Daily Record of Dysfunctional Thoughts (Table 3) and through dialogue, the patient begins to distinguish

TABLE 3
Daily Record of Dysfunctional Thoughts*

Date	Situation Describe: 1. Actual event leading up to unpleasant emotion, or 2. Stream of thoughts, daydream, or recollection, leading to unpleasant emotion.	Emotion(s) 1. Specify sad/anxious/angry, etc. 2. Rate degree of emotion, 1–100.	Automatic Thought(s) 1. Write automatic thought(s) that preceded emotion(s). 2. Rate belief in automatic thought(s), 0%–100%.	Rational Response 1. Write rational response to automatic thought(s). 2. Rate belief in rational response, 0%–100%.	Outcome 1. Rerate belief in automatic thought(s), 0%–100%. 2. Specify and rate subsequent emotions, 0%–100%.

Explanation: When you experience an unpleasant emotion, note the situation that seemed to stimulate the emotion. (If the emotion occurred while you were thinking, daydreaming, etc., please note this.) Then note the automatic thought associated with the emotion. Record the degree to which you believe this thought: 0%=not at all; 100%=completely. In rating degree of emotion: 1=trace; 100=the most intense possible.

*From Beck, A.T., et al. (1979). *Cognitive Therapy of Depression*, New York: Guilford Press.

and to note the relationship between thoughts, events, emotions, and other behaviors. For example, the patient may note that (a) she feels sad (i.e., the emotion), (b) when a co-worker does not say, "Good Morning" (i.e., the situation), and (c) she thinks, "Nobody likes me here enough to say hello" (i.e., the automatic thought). After noticing the covariation between this situation, emotion, and thought, it is understandable that this patient now avoids the office coffee break, i.e., she assumes nobody likes her.

After the patient has learned self-monitoring, she is taught to **identify themes,** ideas which recur across situations, by reviewing past records and sessions (e.g., fearing rejection, seeking approval). By identifying and discussing these pervasive themes, the patient and therapist infer the patient's general rules or silent assumptions.

EVALUATING THE VALIDITY OF COGNITIONS:

Subsequently, **the patient learns to determine the extent to which his or her cognitions** (i.e., automatic thoughts and silent assumptions) **correspond to an objective appraisal of his or her situation.** When the thoughts or assumptions do not match the "evidence," **the patient is taught to revise these cognitions** with more accurate ones and to carry out responses that are consistent with this modified view.

Table 4
Behavioral Techniques*

Activity Scheduling

Mastery and Pleasure Ratings

Graded Task Assignment

Cognitive Rehearsal

Assertive Training/Role Playing

Mood Graph

*From Rush, A.J. (1983). Cognitive therapy of depression: Rationale, techniques and efficacy. *Psychiatric Clinics of North America, 6,* 105-127.

The general process of evaluating the validity of automatic thoughts or silent assumptions is accomplished through a variety of techniques (Tables 4 and 5). When evaluating the validity of cognitions, the first basic goal is to **teach the patient to recognize that thoughts and beliefs are inferences about the world rather than facts. When the patient can conceptualize thoughts as assumptions or hypotheses rather than as facts, he or she can develop some "distance" from the emotions accompanying the thoughts. Hence, the patient learns to scrutinize his or her thoughts by asking questions such as:** what part of my situation is a fact and what part is my belief; what

Table 5
Cognitive Techniques

Recording Automatic Thoughts (Cognitions)
Reattribution Techniques
Responding to Negative Cognitions
Counting Automatic Thoughts
Identifying Assumptions
Modifying Shoulds
Pro-Con Refutation of Assumptions
Homework to Test Old Assumptions
Homework to Test New Assumptions.

*From Rush, A.J. (1983). Cognitive therapy of depression. Rationale, techniques and efficacy. *Psychiatric Clinics of North America, 6*, 105-127.

evidence is there to support or to refute my thoughts; what are some alternative explanations for my thoughts; how would a nondepressed person view my situation; and even if my thoughts match the facts, is it truly as bad as it seems? Through this type of questioning, the patient learns to recognize and to correct logical errors.

In addition to learning to evaluate his or her thoughts logically, **the patient learns to view these thoughts as hypotheses that can be tested.** The patient learns to (a) state his or her cognition in a testable form (i.e., make a prediction), (b) arrange and implement a test of the prediction, (c) record the results, (d) compare the results to the prediction, and (e) query whether additional experiments are necessary to test the validity of the thought. For example, a depressed lawyer reported, "I'm so disorganized and distracted, I'll never complete my work." Such a prediction is especially suited to a common technique used in cognitive therapy called graded task assignment. Through graded task assignment, the patient was taught to operationalize work, e.g., a legal report, and to break it down into small, specific, realistic tasks to be completed over time. Within the experiment, the lawyer predicted she could not even complete the first step of gathering the related legal books and moving all other distracting materials from the desk. Such thoughts which might interfere with the task (e.g., "I'm too incompetent to complete the first step") were

identified and the therapist emphasized partial successes. Each component of completing the legal report was specified, and accomplishing the tasks was viewed as an experiment. Throughout the experiment, the lawyer recorded her progress and compared these results to her initial prediction. At the end of the experiment, she concluded that she was, in fact, able to make some progress on her legal report and had made overly pessimistic predictions that interfered with her working effectively.

HOMEWORK:

One of the most important aspects of cognitive therapy is the "homework" assignment that is completed outside of the therapeutic session. **Homework is tailored to address the automatic thoughts, silent assumptions, or particular symptom targets chosen by the patient and therapist. For an example of a homework assignment see Table 3. Each session includes a review of the homework.** Noncompliance, and any other difficult behavior affecting homework assignments is dealt with using a cognitive model, for example, inquiring as to what thoughts and emotions occurred to the patient when he or she had difficulty beginning the homework.

FREQUENCY, LENGTH, AND MODALITY OF TREATMENT:

To date, there are few studies designed to determine what, if any, relationship exists between the frequency or length of treatment and response to cognitive therapy. One preliminary report suggests that moderately to severely depressed patients evidence fewer dropouts and greater reduction in symptoms when treated twice a week than when treated once a week (Beck et al., 1979). **In research protocols, cognitive therapy typically occurs twice a week for ten weeks,** for a total of 20 sessions. Experienced cognitive therapists recommend that the frequency of the sessions be determined by the severity of the depression; as severity increases, frequency increases.

No controlled studies to date have examined the effect of maintenance or "booster" sessions on therapeutic response for patients who have been diagnosed with recurrent depression. In practice, it is common for patients to participate in booster sessions (once or twice a month) for 6–12 months after routine cognitive therapy.

The typical modality in which cognitive therapy occurs is individual sessions. Rush and Watkins (1981) compared cognitive therapy administered to an individual with a group setting, and found an advantage for the individual modality. Clinical experience suggests that cognitive therapy can also be used with couples as well as with individuals (Rush, Shaw, & Khatami, 1980).

The Effectiveness of Cognitive Therapy

There is ample evidence that the acute phase of cognitive therapy reduces depressive symptoms. Jarrett and Maguire (in press) detailed this literature from 1967 to 1990. Other reviews of this literature include Jarrett and Rush (1986), Dobson (1989), Shaw (1989), and Wilson (1989). In general, the results can be summarized by concluding that cognitive therapy, whether used alone or in combination with antidepressant medication, reduces depressive symptoms during the acute phase more than waiting list controls. When cognitive therapy has been compared with behavior therapy (Gallagher & Thompson, 1982; Thompson, Gallagher, & Breckenridge, 1987) or interpersonal psychotherapy (Elkin, Shea, Watkins, et al., 1989), typically no statistically significant differences are found; these short-term psychotherapies all reduce depressive symptoms. Similarly, when cognitive therapy used alone is compared with pharmacotherapy used alone, no significant differences in reducing depressive symptoms were found by Blackburn and colleagues (1981), Murphy and co-workers (1984), or Elkin and co-workers (1989). However,

Rush and colleagues (1977) and Blackburn and co-workers (1981), when confining their results to referrals from the general practice clinic, reported that cognitive therapy alone reduced depressive symptoms more than pharmacotherapy alone.

The combination of cognitive therapy with pharmacotherapy typically does not reduce depressive symptoms more than cognitive therapy used alone (Blackburn, et al., 1981 [general practice participants only]; Rush & Watkins, 1981; Murphy et al., 1984; Beck, Hollon, Young, et al., 1985; Covi & Lipman, 1987). One exception to this finding is that Blackburn and co-workers (1981) found the combination of cognitive therapy plus pharmacotherapy reduced depressive symptoms more than cognitive therapy used alone in treating psychiatric clinic outpatients. In summary, based on the literature to date, cognitive therapy has been found to be at least as effective as the standard treatment (i.e., pharmacotherapy) in reducing depressive symptoms of outpatients suffering from unipolar major depressive disorder.

Conclusions regarding the prophylactic value of cognitive therapy in reducing depressive relapse/recurrences are premature. In general, the research can be summarized by stating that the relapse/recurrence rate one year after completing the acute phase of cognitive therapy has ranged from 0% (Simons, Murphy, Levine, & Wetzel, 1986) to 50% (Kovacs, Rush, Beck & Hollon, 1981). Methodological problems complicate this literature because the studies were designed to investigate the effectiveness of the acute phase of cognitive therapy rather than the prophylactic effect of cognitive therapy. Promising results have been obtained by Blackburn, Eunson, and Bishop (1986) who suggest the cumulative probability of recurrence to 23%. More research is needed in this area.

PREDICTING RESPONSE TO COGNITIVE THERAPY:

At present there are no definitive predictors of response to cognitive therapy. To date the literature on indications for cognitive therapy should be viewed as hypotheses needing further testing rather than as conclusions ready to guide clinical practice.

At the same time, there are several clinically interesting findings worthy of further study. For example, pre-treatment symptom severity appears to be an important indication for cognitive therapy. Patients having fewer symptoms may show a better response (Simons, et al., 1985; Elkin, et al., 1989; Beckman, 1989; Neimeyer & Weiss, 1990). Similarly, it is noteworthy that although clinicians frequently select treatment modalities based on the extent to which depressed patients have endogenous or nonendogenous symptom profiles, there is little research evidence to suggest that nonendogenous or endogenous patients respond better or worse to cognitive therapy (Kovacs, et al.,1981; Blackburn, et al., 1981). The presence of a personality disorder (Thompson, Gallagher & Czirr, 1988) and the presence of marital discord (Jacobson, Holtzworth-Munroe & Schmaling, 1989) appear to complicate response to cognitive therapy when delivered in its typical format.

Finally, Beck and colleagues (1979) stated early on that individuals with hallucinations, delusions, organic brain syndrome, borderline personality disorder, and schizoaffective disorders may respond poorly when cognitive therapy is conducted in its typical time-limited format. Failure in treating depression with cognitive therapy has been the subject of review by Rush and Shaw (1983). New directions for research on cognitive therapy include adapting cognitive therapy to treat outpatients with recurrent major depression (Jarrett, 1992), depressed children and adolescents (Wilkes

& Rush, 1988), depressed inpatients (These & Wright, 1991), and pharmacologically stabilized bipolar depressed individuals.

Conclusion

Cognitive therapy is an effective approach for treating a subset of nonpsychotic, unipolar depressed adults outpatients. To date, the literature suggests that cognitive therapy reduces depressive symptoms in this subgroup. Whether cognitive therapy reduces relapse or recurrence after the acute phase or in the continuation/maintenance phase remains a subject requiring further study. **Theoretically, it is unclear through what mechanisms cognitive therapy produces its effects, and to what extent the cognitive model accurately describes the development and maintenance of a depression.** Practical issues involving the conditions under which cognitive therapy is maximally effective are yet to be resolved. These questions include when to combine cognitive therapy with antidepressant pharmacotherapy, what are the most effective and efficient modalities for delivering cognitive therapy, and which patients are most likely to respond to this treatment.

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QUESTIONS BASED ON THIS LESSON

9. Which of the following statements is correct?

   A. Cognitions associated with depression are largely voluntary, intermittent, and rarely contain a theme of loss

   B. The private, personal interpretation of events is more critical to the emotional responses that follow these events than the socially popular or acceptable norms of response

   C. Depression is largely caused by the inordinately positive views of self, the world, and the future held by depressed patients

   D. It has been proved impossible to alter patients' automatic reactions to stimuli if the basis for such reactions was established early in life

10. According to cognitive therapy theory:

   A. Silent assumptions are unarticulated rules that influence emotional, behavioral, and thinking patterns in the direction of low self-esteem and depression

   B. The cognitive triad consists of (a) biological, (b) environmental, and (c) psychological influences in depression

   C. Logical errors indicate serious thought disorders, similar to but not identical with those seen in schizophrenic patients

   D. Depression is due to a failure of the patient to be able to distort perceptions, preventing him or her from deriving the usual relief that most people attain by daydreaming and wishful thinking

11. Which type of logical error do patients make when they draw conclusions about their ability, performance, or self-worth based on a single event or incident?

    A. Arbitrary inference

    B. Selective attention

    C. Overgeneralization

    D. Personalization

12. Cognitive therapy:

    A. Does not require rapport or a collaborative alliance between therapist and patient

    B. Involves active questioning of the patient designed to encourage him or her to test the objectivity or validity of specific thoughts or ideas

    C. Follows a strategy of listening and interpretation

    D. Avoids establishing or communicating a rationale for treatment

Directions in Mental Health Counseling

VOLUME 2 • LESSON 4

Existential Aspects of Psychotherapy

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VOL. 2, NO. 4

April 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING (ISSN # 1062-0788, USPS # 008-015) is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

All clinicians employ existential concepts in their approach to psychotherapy, even if they do not consciously acknowledge it. After all, therapy assumes the possibility of change, and the existentialistic vision centers on the issue of becoming, of movement from a particular, presumably unhealthy form of adaptation to a more integrated and effective one.

Existential concepts stress that all time—past, present, future—is equally relevant to the client; therefore, undue emphasis on one to the exclusion of the others does disservice to clients. In fact, they go so far as to see disturbances in the balance of these three temporal modes as an aspect of all emotional afflictions; the depressed person, for example, seems locked into the past, whereas obsessional practices are designed to ward off some future danger, and anxious people are dominated by what might happen.

The separation of subject from object—a basic tenet of traditional scientific investigation—is really not tenable in psychotherapy. In carrying out therapy, we can never eliminate ourselves, our views, or our feelings from the total therapeutic situation. Nor is it realistic to pretend we can evaluate and set goals for clients without due consideration of the interpersonal systems within which they exist.

Existential concepts encourage therapists to give credence to things as they are and not always seek hidden, often unsubstantiated, motives and influences. The question "*how* a client experiences what he or she is experiencing" becomes as important as the question "*why*." They also give us additional ways to view such fundamental issues as humankind's finiteness, the fear of death, guilt, and the need to make choices about the self, about who he or she is, and will become.

The Relevance of Philosophy

Freud (1926) had great reservations about philosophy and its "Handbooks to Life." He insisted that, "...psychoanalysis is not, like philosophies, a system starting out from a few sharply defined basic concepts, seeking to grasp the whole universe" (1922). Philosophy has, indeed, little to offer to psychotherapy if it presents itself as a rigid "system" trying to encompass the multitude of phenomena by reducing them to a few "basic concepts."

Another matter is the philosophical orientation all of us inevitably bring to whatever we undertake. Every therapist brings, consciously or unconsciously, a certain view of humanity to the pursuit of therapy; a view of the individual's position in the world and to other people—in that sense we are all philosophers.

Existentialism, as I see it, is not a school of philosophy but a philosophical orientation, a way of viewing the human position in the world. Most of the thinkers who have been called existentialists have rejected the label, and it is of the very essence of existential thought not to be a "school," rather to be unsystematic. In this way, it falls outside Freud's description of a philosophy.

What existential thinkers share is their approach to certain experiences, such as the experience of the other person, of time, of death. To the extent to which these experiences concern us as therapists and counselors, a consideration of the existential approach to them can be of help and interest.

Is There a School of Existential Therapy?

Just as there is no school of existential philosophy, I do not think that there is a school of existential therapy. Though Medard Boss (1963), a friend of the existential philosopher Martin Heidegger, distinguishes "Daseinsanalysis" ("Dasein," literally "being there," is the term Heidegger uses for human existence) from psychoanalysis, in his actual practice he is a psychoanalyst. On the other hand, Salvatori Maddi's article "Existential Psychotherapy" (1985) proposes "strategies" that are clearly cognitive. A great many psychotherapists resemble each other in their existential orientation while adopting very different techniques—there are, for example, group therapists and family therapists each of which may call themselves "existential."

The Meaning of Existence

In order to elucidate some of the existential ideas, we need to inquire into the meaning of the word "existence." As most existential philosophers, particularly Heidegger, believe in the etymological examination of words, this inquiry into the meaning of "existence" constitutes an existential practice in itself.

"Existence" has its roots in the Latin verb ex-sistere which means literally "to stand out," and then "to emerge, to proceed." It carries a sense of movement, of "becoming," of "being" as a continuous process (Onions, 1969). This meaning is very different from everyday usage where we talk of "mere existence." Insofar as all psychotherapy assumes the possibility of change, existence as "becoming," as a process, seems to be implied in most therapeutic endeavors, unless they rely on a mechanistic concept of humanity where therapy would simply be a rearrangement of parts.

Existential Time

"Becoming," "process," and "change" imply an element of time. This is not our everyday linear clock time which is a useful mechanical device of measurement but of limited use when applied to the dynamics of experience. **At any particular moment—the present—I still carry the past within me and live towards a future.** For example, when I fall in love, my relationship with people close to me in the past as well as my wishes and expectations will enter the process. Time is three-faceted, and a dimension of existence (Heidegger, 1926/1962).

Time and Psychotherapy

The exploration of the past was, from the very beginning, the task of psychoanalysis, and the phenomenon of transference—the projection of an important figure from the past onto the therapist—showed the survival of the past into the present. If the relationship between client and therapist is reduced to the relationship of the client with the past figure, the "present" aspect of the situation is neglected, and the existential concept of time is violated. The existential view would be that past and present are always there together. It is, in fact, difficult to see how therapy could affect a past that is truly "past."

If one mode of time can be seen as more important than the others, it is that of the future, though it has perhaps not received sufficient attention from the psychotherapists. Heidegger saw a human being as always "ahead" of himself/herself, and the very concept of "becoming" points toward the future. All therapy wishes to bring about change, that which is "not yet," and our hopes and expectations affect our memories, our dreams, our experiences.

An important aspect of our future is our death. Its inevitability is implicitly present in all our experiences. **The fact that our existence is limited in time is part of the reality of psychotherapy.** More will have to be said about this at a later point.

Time and Emotional Disturbance

Disturbance in the balance of the three temporal modes (past, present, and future) is an aspect of all emotional afflictions. Minkowski describes a schizophrenic who is unable to make a connection between one day and the next: the client's present lacks both the past and the future. **Depressed persons have bound themselves to the past. Obsessional practices are meant to ward off the future.** Anxious people are dominated by what might happen.

Macquarrie (1972) points out that an overconcern with possibilities can lead to wish-fantasies and what he calls "irresponsible idealism." A denial of possibilities, on the other hand, makes people submissive to authority and the status quo. It is as if they had dropped the "ex" from *ex-sistere*.

The most important denial of the future manifests itself in the denial of death. Yalom (1980) has explored the emotional pathology rooted in this denial with great thoroughness.

Being-In-The-World

Heidegger (1926/1962) has shown that one of the most important characteristics of human existence is that it is temporal—"in time." He also says that it is always

"being-in-the-world." What does he mean by that? Two things need to be noted in this expression—the special use of the word "in," and the hyphens. The use of "in" here is not meant spatially, as when I say "I'm sitting in my car." I can get out of my car, I can dispose of my car: but I cannot get out of the world, I cannot dispose of it, I am always "in" it. **The "in" here indicates a state of mutual interrelatedness, as the warp and weft of a carpet. The world and I cannot be seen except in relation to each other.** The use of the hyphens underlines this meaning.

But Heidegger does not leave it there. He goes one step further and stresses that **we are always in the world *with others*.** "By 'Others' we do not mean everyone else but me—those over against whom the 'I' stands out. They are rather those among whom one is too." Heidegger, in this rather cryptic saying, emphasizes again the mutual relation between me and others: they are not just independent entities who are also there, I am "among" them, connected with them.

A client's relation to "the others," his or her parents as a child, his or her wife or husband later on, his or her therapist here and now is, of course, of crucial concern to psychotherapy. Heidegger's way of describing our being in the world with others gives this concern its philosophical underpinning. Humankind, he implies, is always an integral part of the human context and cannot be understood in isolation.

There is a growing realization of the importance of "context," of interrelatedness and interaction. In various disciplines, and particularly in group work and systems-oriented therapies, "context" and "system" seem to me to have implications very similar to the existential notion of "being-in-the-world."

Rejection of the Object-Subject Split

One of the consequences of proposing a mutual relation between myself and the world is that **the world cannot be just an object for my observation:** I always have to consider myself and the world together. **The separation of subject from object on which traditional science is based cannot be maintained.** (This is, of course, what puzzled atomic physicists—that the observer and the observed could not be separated.)

This has great relevance for psychotherapy. Freud thought that the therapist/observer, as long as he or she did not reveal anything about himself or herself, could receive an "objective" picture of the client. **Most therapists and counselors would now admit that, whatever technique they use, they can never eliminate themselves—their views and feelings—from the total therapeutic situation.** The psychoanalyst Neville Symington (1983) wrote: "I think at one level the analyst and the patient together make a single system. Together they form an entity which we might call a corporate personality." And what the psychotherapeutically oriented physician Victor von Weizsäcker (1949) said about the relationship between doctor and patient is perhaps particularly true of the psychotherapeutic situation: **"It always seems to me important that in a comprehensive therapy the doctor lets himself be changed by the patient, that he allows himself to be affected by the wealth of impulses reaching him from the patient..."**

As Medard Boss (1962) points out, what we call projection, identification, and transference are no more than "a tossing-out and carrying-over of psychic contents"

unless they are understood as phenomena in a shared world, as a manifestation of "the primary, intrinsic being-together of all men in the same world."

The Phenomenological Aspect

We have seen that the therapist or counselor cannot "observe" the client like an object. The therapeutic situation is one of immediate mutual experience. This is its phenomenological aspect. What do we mean by that? **Phenomenology** is an approach to knowledge proposed and worked out by Edmund Husserl, a teacher of Heidegger. **It stresses knowledge by experience rather than by explanation of causes and origins.** As Robert C. Solomon (1972) explains, "Husserl demands: **Describe phenomena, don't superimpose theories on them and don't populate an imaginary 'behind-the-phenomena' stage with unknowable 'things-in-themselves.'" Phenomenology's central question is: "*how* is it" rather than "*why* is it so?"** A phenomenological approach has always been part of the existential view.

The relevance of psychotherapy becomes clear when we consider one of Freud's sayings in the **Introductory Lectures on Psychoanalysis** (1916-1917): "The phenomena perceived must yield in importance to the trends which are only hypothetical." **Psychoanalysis and psychoanalytic psychotherapies have tended to neglect what "meets the eye" in favor of digging for roots and causes** (the word phenomenon means literally "the thing that appears"). An existential approach would be concerned with whatever showed itself in the meeting between therapist and client where it is not only interested in the internal structure of disturbed behavior and its "psychodynamics," but also in the way it manifests itself, i.e., its "quality."

Embodiment

We have seen that our immediate experience is always one of being in the world with others. It is also one of being in a body. "...Man's somatic aspect is inseparable from his being-in-the-world. Man...participates bodily in all his world-relationship" (Boss, 1963). Just as our understanding of "being-in-the-world" undercuts the object-subject split, the idea of a person always being in a body undercuts the Cartesian dichotomy between the body and mind. Existential thinking considers this dichotomy an intellectual speculation that is not rooted in experience. People's age-old efforts to bridge the gap between body and mind are doomed to fail, as they try to bring together what is not existentially separate.

The concept of "embodiment," of the body-lines of existence, is clearly of great relevance to psychotherapy, particularly in the area called "psychosomatic medicine." Within this area, causal connections are still assumed. This leads to difficult propositions of the kind that the repression of aggressive feelings "causes" high blood pressure. How such a jump from the emotional to the physiological sphere could come about remains quite unclear. An existential approach would propose that all existence reveals itself as both physical and mental (if I may use this word to cover both cognitive and emotional aspects), so that there is no gap to be bridged.

The Priority of Existence

The central importance of immediate experience was expressed by Sartre (1946/1948) in his much-quoted and controversial sentence, "Existence precedes essence."

What does this mean? There are black and brown pianos, uprights and grands, Steinways and Blüthners. But the "essence" of a piano is what all pianos have in common, what makes a piano a piano; its "definition." The definition of the piano in the *Oxford Concise Dictionary* is a "musical instrument with metal strings struck by hammers worked by levers from a keyboard...." There is a way in which I can say that *the* piano is "prior" to all the individual pianos that have been or could be made.

This, as Sartre saw it, was not so with humanity. **There is, of course, a definition of the human too. In the *Oxford Concise Dictionary* it reads: "Human being, individual of genus Homo, distinguished from other animals by superior mental development, power of articulate speech, and upright posture...." But Sartre gave "priority" (chronologically and logically) to individually existing men/ women and their immediate experience of themselves.** Let me quote him more fully: "What do we mean by saying that existence precedes essence? We mean that man first of all exists, encounters himself, surges up in the world—and defines himself afterwards" (1943/1958). There is, in Sartre's radical view, no such thing as "the nature of man." Humans define themselves as they go along.

Existence and Essence in Psychotherapy

Sartre's bold statement makes the psychotherapist or counselor face some difficult questions. What is "essence" in our clients, and what is "existence?" Has one "priority" over the other?

We can say that psychoanalytic theory (like all theory) has formulated certain "laws" which are assumed to underlie all human behavior. Examples of this are

Freud's account of infantile sexuality and the Oedipus complex, or Melanie Klein's proposition of the move from the schizoid to the depressive position. To the extent to which these and other developmental phases are common to all people, they can be called "essential."

On the other hand, when we meet a client, we meet that particular client, different from any other, with his or her unique way of speaking, moving, being, and of affecting us as no other person has ever done or ever will. This is the existential aspect of therapy, and where we put the "priority" in our work, whether on the essential or existential aspects, will depend on our training and the kind of person we are. But the existential aspect is never entirely missing, I think, whether we call ourselves "existential" therapists or not.

The Problem of Choice

Another important question emerges from Sartre's proposition and concerns us as psychotherapists or counselors. Sartre says that the individual "defines" himself or herself, chooses what he or she is to become. But how much choice do our clients have? How far are they suffering from what they have *not* chosen—their genetic inheritance and the influences of background and upbringing? Is not the feeling that their ability to choose is crippled one of the reasons why they come to us for help?

Existential thinkers do not deny that we often find ourselves in situations that we have not chosen. What we *can* choose is our relation to the situations in which we find ourselves. "Man is always free within his situation to confer signifi-

cance on that situation" (Solomon, 1970). One could see it as an aim of psychotherapy to "free" clients for a more fruitful engagement with the circumstances in which they find themselves.

The question of choice touches on a paradox inherent in psychotherapy. Clients comes to us in the hope that we will help them to change their incapacity to change. If we could not assume that clients have access to an area where choice is possible, no matter how limited this area may be, psychotherapy would be inconceivable.

Two Kinds of Anxiety

Making a choice means taking on a responsibility, and this generates anxiety. Anxiety is "the dizziness of freedom," in Kierkegaard's words (1844/1944), and freedom is understood here as both opportunity and threat. Sartre (1943/1958) puts it similarly: "Anguish is the reflexive apprehension of freedom itself."

This is not the kind of anxiety psychotherapists expect to meet in their clients. The concept of anxiety that prevails in most schools of psychotherapy is the one formulated by Freud. Freud changed his view of anxiety in the course of his life. At first (1916-1917), he thought of it as "the universally current coinage for which any affective impulse is or can be exchanged if the ideational content attached to it is subjected to repression." Later (1933) he saw it as "signaling" an external or internal danger. While in the beginning anxiety seemed to him a direct *product* of repression, he saw it as a warning *leading* to repression. By the time he had altered his view of anxiety, he had also formulated his concept of a "death instinct," so that the dangers against which anxiety is warning us are rooted in our aggression as much as in our sexuality.

The existential view of anxiety does not replace the psychoanalytic one; it explores a different aspect of this multifaceted affect. A person's capacity to choose his or her attitude to what is given, and the responsibility for his/her own life that this entails, may generate an anxiety that leads to a denial of this responsibility, of this freedom to choose. This denial, as all denial of our potentialities, has its own pathological manifestations. In Tillich's (1952) words, "Pathological anxiety leads to self-affirmation on a limited, fixed, and unrealistic basis and to a compulsory defense of this basis." Neurotic symptoms are frequently a defense against the anxiety that the possibility of choice engenders.

Tillich (1952) mentions yet another form of anxiety for which a Freudian explanation is insufficient—the anxiety rooted in a loss of meaning: "The anxiety of meaninglessness is anxiety about the loss of an ultimate concern, of a meaning which gives meaning to all meanings." This anxiety too may manifest itself in mental disturbance.

Another kind of anxiety that is not covered by the Freudian concept and that is an aspect of existence itself is our fear of death. "The terror of death is ubiquitous and of such a magnitude that a considerable portion of one's life energy is consumed in the denial of death" (Yalom, 1980). This denial also leads to disturbances of various kinds, and therapists need to be attentive to this "repression" of a future event.

Perhaps we need to distinguish between two different kinds of anxiety—anxiety generated by the threats of our instinctual life ("neurotic anxiety") and anxiety produced by the threats of the very process of existence itself ("existential anxiety"). Freud (1916–1917) seems to give us a hint of this twofold nature of

anxiety by considering the "act of birth" as a "prototype" of all later anxieties, though he only sees the physiological and not the existential implications of this.

Two Kinds of Guilt

As we have seen, **a person's choice to take responsibility for his or her own life, engenders anxiety. Avoidance of this choice engenders guilt.** This is not the guilt psychotherapists usually talk about. As Tillich (1961) puts it: **"Neurotic guilt is misplaced compulsory guilt feeling and not the existential experience of being guilty of a definite concrete act which expresses the general estrangement of our existence, an act for which responsibility cannot be denied...." The denial of our capacity to make choices and the denial of the limitation of our existence are examples of living "inauthentically" and may generate a feeling of having betrayed ourselves, a feeling of existential guilt.**

Freud (1933) sees guilt as a reaction to the dictates of the superego which has absorbed parental aggression as well as the aggressive feelings of the child against the parents. It is rooted in our relation to internalized convention and authority, and as such it is a social phenomenon.

Freud does not distinguish between superego and conscience. Heidegger (1926/1962), however, believes in "the voice of conscience" as a "primordial phenomenon" which "has the character of an appeal to 'Dasein' (human existence) by calling it to its ownmost potentiality for Being-its-Self." **Conscience calls us back from denial and avoidance,** from the lostness in inauthenticity.

"Existential guilt," says Martin Buber (1964), "—that is guilt that a person has taken on himself as a person and in a personal situation—cannot be comprehended through such categories of analytical science as 'repression' and 'becoming conscious.' " As examples he mentions "the inner consequences of man's betrayal of his friend or his cause."

The German word for "guilt" is "Schuld" which also means "debt." Boss (1963) refers to this when he says: "Man is aware of existential guilt when he hears the never-ending call of his conscience. This essential, inevitable being-in-debt is ***guilt***, and not merely a subjective ***feeling*** of guilt."

Existential and neurotic guilt are two facets of a complex phenomenon, and it is important to make a distinction between them. Neurotic guilt may need to be dissolved: existential guilt may need to be acknowledged. And sometimes neurotic guilt will be found to be a displacement of existential guilt.

Is There an Unconscious?

Therapists and counselors with an existential orientation do not agree on whether to accept or reject Freud's concept of an unconscious. Boss (1963) has no doubts about it: "One of the immeasurable advantages of the Daseinsanalytic understanding of man lies in its making superfluous the assumption of an unconscious....Daseinsanalysis can elucidate without difficulty, on the basis of immediate experience alone, all those psychic phenomena that forced Freud to invent the unconscious." He grants that there are "modes of being" of which we are not fully aware. What he opposes is the division of experience into two different realms

with two different languages and the necessity to translate the language of the "unconscious" into that of consciousness in order to make it "valid." "All of the client's modes of behavior—those openly carried out and those so far warded off—are considered autonomous by the therapist" (Boss, 1963). An example of Boss's view is his approach to dreams. He refuses to distinguish between content and meaning of a dream: the dream means what it says.

Rollo May (1958) diverges from Boss's view. He admits "that the doctrine of the unconscious has played most notoriously into the contemporary tendencies to rationalize behavior, to avoid the reality of one's own experience, to act as if one were not himself doing the living." He calls this the "cellar" view of the unconscious which he too rejects. But he proposes another way of looking at it. "Freud's great discovery...was to enlarge the sphere of the human personality...to include...the 'depths', that is, the irrational, the so-called repressed, hostile and unacceptable urges, the forgotten aspects of experience....The symbol for this vast enlarging of the domain of the personality was 'the unconscious'" (May, 1958). May suggests that the concept of the unconscious as a symbol for a "radical enlargement of being" should be retained.

Existential Aspects of Psychotherapy: A Summary

EXISTENTIALISM AS A PHILOSOPHICAL ORIENTATION:

Existentialism is not a school of philosophy but a philosophical orientation, with a particular way of viewing humankind in their relation to the world and to others. Its important aspects are:

1. **Existence is seen as a process,** the individual as "becoming."

2. **Time is a dimension of existence whereby "now" always includes the past and points to the future.**

3. **An individual has to be seen as part of the whole human context** and cannot be understood apart from it.

4. In this context, **individuals are in mutual relation to each other,** and **"objectivity" and "detachment" are not possible.**

5. **Immediate experience has priority over theoretical assumptions,** and what "appears," the phenomenon, has to be taken seriously.

6. **All experience is both mental and physical,** and the body-mind dichotomy is an abstraction.

7. No matter in how many ways people are conditioned, we must assume that **they have access to an area in which they are** capable of choice, and moreover that they are responsible for **this choice.**

THE EXISTENTIAL TENETS OF EXISTENTIAL PSYCHOTHERAPY:

There is no "school" of existential psychotherapy, in the sense in which we talk of a Jungian or a Freudian school, but **proponents of most schools may stress the existential aspects of their work.** This may affect the choice of their models and

their techniques, but it **does not create entirely new models and techniques.** One could even say that the very process of psychotherapy implies certain existential tenets. What is the relation between these tenets and the psychotherapeutic process?

1. **The view that existence is a process and that the individual is capable of change is fundamental to psychotherapy.**

2. The existential view of time as a "now" containing the past and pointing toward the future is at the core of the therapeutic endeavor: **the client "presents" an unfinished past in the hope of creating a new future. The acceptance of death as an inevitable aspect of our future needs to be faced** as an important element in the psychotherapeutic process.

3. **We never meet just an individual client, we also meet in that client his or her "context," that is his or her family, other significant figures, etc.**

4. The client cannot be an "object" observed by a detached therapist: **client and therapist always affect each other mutually.**

5. In any psychotherapy, it is important to **be open to whatever the client brings,** verbally and nonverbally, and **not to impose theoretical assumptions in the "phenomena."**

6. So-called "psychosomatic" symptoms can be more easily comprehended if **all experience is understood to manifest itself in both mind and body.**

7. If we accept that a person is capable of choice and is responsible for his or her choice, we need to introduce **new dimensions of anxiety and guilt into our work as psychotherapists.** For being confronted with choice engenders a kind of anxiety that is different from "neurotic" anxiety, and avoiding choice engenders a kind of guilt that is different from "neurotic" guilt feelings.

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Questions Based on This Lesson

13. Which of the following statements is correct?

    A. Existentialism is exclusively a philosophy without relevence to psychotherapy

    B. In the existential aspect of psychotherapy, past and future are irrelevant and only the here and now matters

    C. Since all psychotherapy assumes the possibility of change, existence as "becoming" seems implied in most therapeutic endeavors

    D. In the existential aspect of psychotherapy, only the past assumes any significance

14. In the existential approach to psychotherapy:

    A. Mind and body are seen as distinctly separate

    B. The total separation of subject (therapist) from object (client) cannot be maintained

    C. The central question asked, again and again, is "why is this so?" not "how is it?"

    D. Nothing new is added that has not already been elucidated in the writings of Freud

15. According to existential psychotherapists:

A. The situations in which we find ourselves are entirely due to our own choices

B. What we can choose is our relation to the situations in which we find ourselves

C. The goal of psychotherapy is to induce changes without choices

D. Making choices never generates anxiety except in neurotic clients

16. Which of the following statements is correct?

A. Neurotic guilt may need to be resolved in therapy whereas existential guilt may need to be acknowledged

B. There is no difference between superego and conscience in existential thinking

C. Avoidance of the choice to take responsibility for one's own life is a healthy way to avoid guilt

D. Existential psychotherapy presents a theory and a strict set of guidelines that vie with other schools of thought to become the primary orientation of all psychotherapists.

Directions in Mental Health Counseling

VOLUME 2 • LESSON 5

Depression and the Immune System

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VOL. 2, NO. 5

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DIRECTIONS IN MENTAL HEALTH COUNSELING (ISSN # 1062-0788, USPS # 008-015) is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

As the general public becomes much more aware of the immune factors in health and illness, therapists are increasingly confronted by clients who will inquire about the possibility of such factors influencing or being influenced by their mental and emotional states. Although facts about immunology are necessarily somewhat technical, it seems useful for therapists to have sufficient knowledge of the field to at least be familiar with its concepts, current research, and the implications thereof. Moreover, as more progress is made in this area, more insight into mind-body interactions will emerge.

The powerful interactions between mind and body have recently been highlighted by investigations into the connection between stress and the immune system. Psychological stress—or the inability to cope successfully with stress—has been clearly linked to an increase in the incidence or severity of physical disease. The immune system, one of the body's major defenses against toxic and pathogenic substances, including malignant cell bodies, is sensitive to neuroendocrine hormones and neurotransmitters and is probably an important mediator of such an influence.

In this lesson, the authors present a brief sketch of how the immune system operates, describe several methods used to assess immune function, and offer experimental evidence for the effects of glucocorticosteroids, catecholamines, endorphins, and enkephalins on immune function.

Several studies suggest diminished immune function in states of depression. For example, depressed men who had recently experienced a death or serious illness in the family showed an impairment in their ability to respond to mitogens and allogenic cells. In another study, depressed patients showed a reduced response to mitogens,

and, in a third, a significant decrease in the proportion of CD4 and CD2 cells. Whether these changes are directly related to depression, to the hormonal changes and neurotransmitter changes reported to occur in depressed individuals, or to other behavioral features, such as heavy drinking, smoking, sleeplessness, dietary changes, or medications, remains unclear.

If, however, periods of depression are associated with reduced immune competence, then these must be viewed as episodes during which the depressed person may be especially at risk for other physical illnesses. If the depression is not recognized and managed properly, illness, even death, may follow, as suggested by the increased morbidity and death rates among men during the first year after being widowed or following retirement.

Interactions between the Brain and the Immune System

There is a popular belief that the mind can determine susceptibility to disease. The evidence which exists from clinical studies and animal models to support this concept has recently been reviewed (Gorman & Locke, 1989; Dantzer & Kelly, 1989). **The data indicating a role for the psyche in influencing both the severity and incidence of infectious disease, particularly viral infections, are convincing. There are also intriguing data suggesting associations between the mind and autoimmune diseases, including allergies, and cancer. In most of these studies, psychological factors, such as stress or an inability to cope with stress, have been linked to an increase in the incidence or severity of illness. Other studies, however, indicate that stress can be protective under certain circumstances.**

In recent years, attention has focused on changes in the immune system as a mechanism by which psychological factors can influence disease processes. The immune system seems a reasonable choice for transforming psychological signals into somatic ones. For one thing, in all the above-mentioned diseases, the immune system plays a potentially prominent role. There also is ample evidence that the immune system is sensitive to neuroendocrine hormones and transmitters. Thus, disregulated immune function can be expected to alter susceptibility to these diseases. Immune reactivity is modified by glucocorticosteroids, ACTH, the endorphins and enkephalins, catecholamines, and acetylcholine. This is a fact largely ignored by immunologists. Marx (1985) points out that it is time for immunologists to recognize that the immune system "belongs in the body." There is also a fascinating body of evidence that shows that the immune system can influence the mind. For example, following antigenic challenge, the neuronal firing rate in the hypothalamus increases and plasma

cortisol levels increase as well (Besedovsky, et al., 1983). This increase in cortisol may be in response to an ACTH-like molecule which activated lymphocytes can produce (Smith & Blalock, 1981). Thus, it seems clear that the immune system and the brain can interact, and that this interaction might well influence disease processes.

While theoretically this concept has great appeal, it has been difficult to document in human beings. However, animal models have clearly demonstrated that psychological stress can increase the growth of tumors and susceptibility to infections. Such models also show that the same stressors reduce immune function. While there are many parallels between human and murine immune systems, there are also some important differences. One of these is the different ways the two systems respond to glucocorticosteroids. Of course, one must be cautious in extrapolating research done in mice with humans.

In humans, work in this area is hampered by natural variability between individuals, the enormous complexity of the immune system, and the formidable complexity of the neuroendocrine system. A promising new approach to this problem has been to focus on individuals with major psychiatric depression. The severity and duration of this condition allows significant differences in immune function to be correlated with alterations in neuroendocrine hormone levels. Results of research in this area are reviewed later in this lesson.

The Immune System: An Overview

The immune system acts to protect us from a large variety of pathogens and toxins. It first recognizes these elements as being foreign and then uses one of several mechanisms at its disposal to eliminate or inactivate them. Immune responses are

divided into those that involve antibody (termed humoral responses) and those that involve cell-mediated immunity. In addition to pathogens, the immune system has the capability to **recognize and destroy transformed or cancerous cells.** It can, with some cancers, protect against the growth and metastasis of tumor cells. However, the **immune system is not infallible, as those of us with allergies or autoimmune disease can attest.** The list of diseases classified as autoimmune continues to grow and includes rheumatoid arthritis, myasthenia gravis, and certain forms of diabetes and asthma. To prevent misplaced reactivity and to limit the exuberance of otherwise appropriate immune reactions, the immune system includes a variety of checks and balances. A brief overview of the components of the immune system and how they interact is given below.

TABLE 1
Cells of the Immune System

Cells	Cell Markers	Cell Products	Function
Lymphocytes			
B Cells	IgM, IgD, IgG, IgE, IgA	Antibodies	Antibodies inactivate some viruses and bacteria, and target other pathogens for destruction by other cells of the immune system
T Cells	CD3, CD2, CD4 or Leu 2 (on helper/inducer cells) CD8 or Leu 2 (on cytoxic/ suppressor cells)	Lymphokines (eg, IL-2, interferon, B Cell growth factor)	Regulate function of B cells, effector T cells, and macrophage; cytoxic T cells kill infected host cells and neoplastic cells
NK Cells	HNK-1	Interferon	Kill certain virally infected and neoplastic cells
Macrophages	Mo1, Ia	IL-1, interferon, H_2O_2, prostaglandins	Bactericidal, tumoricidal, accessory role in immune reactions

The immune system is remarkably complex. Its central players are the lymphocytes which provide specificity and memory. Each lymphocyte can respond to only one or a closely related set of antigenic determinants. Having been stimulated by its appropriate antigen, some lymphocytes differentiate to become memory cells. Memory cells are more sensitive than naive lymphocytes and respond rapidly to subsequent encounters with antigen. Other lymphocytes differentiate into effector or regulatory cells after an encounter with antigen.

The lymphocytes are divided into B cells, T cells, and null cells. B cells produce antibodies, T cells provide specific cell-mediated immunity, and null cells can provide a quick but non-specific form of cell-mediated immunity. B cells are, in turn, subdivided according to the type of immunoglobulin they carry on their surface, i.e., IgM, IgD, IgG, IgA, or IgE. The different antibody classes have different functional roles. IgA, for instance, is released into secretory fluids and may be particularly important in preventing respiratory infections. Antibodies, in general, coat pathogens and help inactivate them or target them for destruction by the granulocytes and the reticuloendothelial system.

T cells are subdivided into functional subgroups. There are helper, inducer, suppressor, and cytotoxic T cells. These cells are described below. To a large extent T cells can be classified according to certain surface antigens they possess. Helper and inducer cells are generally positive for the CD4 antigen; suppressor and cytotoxic cells are generally positive for the CD8 antigen.

Null cells are a heterogeneous collection of lymphoid cells which cannot be classified as B or T cells. They include immature T and B cells as well as natural killer cells.

Natural killer (NK) cells can kill certain tumor and virally infected cells. In animal models, NK cells can be shown to be important in the early stages of certain viral infections, and in clearing certain tumor cells, particularly from the lungs.

The T cells are the cells that orchestrate the immune response. Let us consider antibody production as an example. **Although B cells can recognize antigens directly, they require additional signals, provided by T helper cells, to proliferate and differentiate into memory or antibody-secreting plasma cells.** The T helper cells not only stimulate B cells, but also amplify the antibody response by inducing proliferation and differentiation of other relevant T helper cells. **T inducer cells help control the reaction by activating suppressor cells that can then turn off T helper cell activity.** T cells produce factors such as immune (gamma) interferon and interleukin-2 (IL-2 or T cell growth factor), called lymphokines. The lymphokines are now recognized as important immunoregulatory molecules.

In other situations other T cells can be activated to become cytotoxic cells. These cells can kill pathogens, host cells infected with viruses or other intracellular pathogens, and transformed cells. T cells can also activate other cells such as macrophages to become batericidal or tumoricidal.

Monocytes and macrophages are important in the initial stages of an immune response when they act as accessory cells. These cells process antigen, present in a particularly antigenic form to T cells, and produce factors which stimulate B and T cells. At other times macrophages that have become activated can act as suppressor cells and inhibit the immune response through the release of suppressive factors such as prostaglandin E.

Thus the immune system includes both effector and regulatory cells which interact to produce humoral and/or cell-mediated responses. Contact with antigen will stimulate a network of reactions. The end result depends on which of these pathways predominate. This in turn depends on the number and type of competent cells available for interaction.

Measurements of Immunocompetence

There are a variety of tests used to try to assess general immunocompetence. One such measure is performed *in vivo*. It measures the delayed type hypersensitivity reaction to 5–7 commonly encountered antigens. It requires antigen recognition, migration, and activation of T helper cells and macrophages.

A simpler measure of immunocompetence is the *in vivo* mitogen test. Mitogens are substances, such as the plant-derived phytohemagglutinin (PHA) or concanavalin A (conA), which stimulate lymphocytes to divide. PHA and conA are called T-cell mitogens because they stimulate the majority of T cells. Mitogenesis requires T-cell–macrophage cooperation and the production of many of the same factors needed to produce effective humoral or cell-mediated immunity. One quantitates activation by the amount of radioactive thymidine cells incorporate when cultured in the presence of mitogen. Other mitogens such as pokeweed mitogen (PWM) predominantly stimulate B cells to proliferate but require T cells as helpers.

The quantitation of lymphokine production in response to a stimulus is another measure of immunocompetence. IL-2 in culture supernatants, for instance, can be measured by its ability to promote the growth of certain T-cell lines. The amount of proliferation is directly related to the concentration of IL-2 (T-cell growth factor).

NK-cell activity is measured as the release of an isotope, such as chromium, from labeled sensitive target cells. Most commonly the tumor-cell line arbitrarily called K562 is used as a target cell. The damaged cells release isotope into the culture supernatant which is then counted in a gamma counter. The percentage of target cells killed is a measure of NK-cell activity.

An additional assessment of immune status can be obtained from the quantitation of the number or proportion of CD4 (helper/inducer) and CD8 (suppressor/cytotoxic) cells. While moderate changes in the overall CD4/CD8 ratio may not mean that much, major changes tend to indicate a severely disregulated immune system. In acquired immunodeficiency syndrome (AIDS), for instance, a retrovirus infects CD4 cells and leads to a gradual reduction in their number. This is felt to be the major event in the pathogenesis of AIDS which leaves its victims unable to combat infections from opportunistic organisms. Other antigens such as CD3 or CD2 can be used to measure the total number of T cells present.

Interaction of the Immune System with the Neuroendocrine System

The immune system is responsive to regulation by a number of neuroendocrine hormones. The effects of the glucocorticosteroids have been studied extensively. In certain species, such as rats and mice, corticosteroids actually destroy immature T cells. This, however, is not the case in humans (Cupps & Fauci, 1982). In humans, glucocorticosteroids, however, are generally immunosuppressive when given at high doses. Both lymphocyte migration patterns and lymphocyte and macrophage function are affected. The effect of the glucocorticosteroids depends on the

subset examined, the location of the population studied, and the time of addition of steroid relative to antigen. In mice, for instance, the antibody response in the spleen is suppressed at the same time that the antibody response in the bone marrow is enhanced following steroid administration *in vivo*. This is, in part, probably due to the redistribution of competent cells. Glucocorticosteroids suppress secretion of early activation factors by lymphocytes and macrophages. However, once activated, macrophages produce a factor that protects T helper cells from the inhibitory effects of glucocorticosteroids. In certain models, dexamethasone can, in fact, enhance antibody responses because of a differential effect on suppressor cell activity; that is, by inhibiting suppressor cells, the net reaction is augmented. Thus, at moderate doses, the effects of steroids can be rather complicated.

Catecholamines can also influence both the function and distribution of lymphocytes. Catecholamines have been reported to suppress antibody production when added to lymphocyte cultures but to enhance NK activity if cells are preincubated with norepinephrine. *In vivo* their effect seems to be caused in part by their ability to change the distribution of lymphocytes. Crary and co-workers (1983) reported that the injection of epinephrine into volunteers caused a rapid increase in

TABLE 2

The Influence of Neuroendocrine Hormones and Transmitters on Lymphocyte Function*

Suppressors	Enhancers
ACTH	acetylcholine
epinephrine	arginine vasopressin
endorphines	endorphins
glucocorticosteroids	enkephalins
norepinephrine	glucocorticosteroids
serotonin	growth hormone
somatostatin	insulin
	oxytocin
	prolactin
	substance P

*Note: Certain modulators such as the endorphins and glucocorticosteroids can either enhance or suppress immune function depending on their dose, time of addition, and type of function assayed.

the total number of lymphocytes in the peripheral blood. There was a relative decrease in the proportion of CD4 cells, and a relative increase in the proportion of NK cells. Cells drawn at this time for *in vitro* testing had a reduced ability to proliferate in response to the T-cell mitogen PHA. However, adding epinephrine to mitogen cultures *in vitro* or preincubating cells with the catecholamine prior to mitogenic stimulation had no effect. This suggests that the *in vivo* effect of epinephrine on the mitogen response was due to the change in the relative proportion of the lymphocyte subsets in the circulation, rather than to a direct effect of epinephrine on the lymphocytes. The alterations caused by a bolus of epinephrine *in vivo* were maximal at 30 minutes and had returned to normal by two hours. Alternatively, *in vivo* administration of epinephrine could induce other neuroendocrine changes that could secondarily affect mitogenesis.

Neuropeptides have also been shown to have immunomodulatory properties. Both the endorphins and enkephalins can influence immune function; however, the literature is somewhat contradictory. Beta-endorphin is reported to stimulate or suppress mitogenesis. Alpha-endorphin and the enkephalins reportedly suppress *in vitro* antibody synthesis. NK-cell activity is also modulated by beta-endorphin. *In vitro* beta-endorphin can stimulate NK-cell activity, but the effect is not mediated via an opiate receptor. In contrast, in *in vivo* experiments, electrical shocks given in a particular protocol resulted in reduced NK-cell activity. The effect could be blocked by naloxone (Narcan), suggesting the effect was mediated by endogenous opiates binding to opiate receptors. (Both lymphocytes and macrophages have opiate receptors.) Additional work also suggests that endogenous opiates may influence immune status *in vivo*. Injection of leucine enkephalin or methonine enkephalin was shown to cause an increase in thymic and a decrease in splenic weight in mice.

Alterations in the Levels of Neuroendocrine Hormones in Depression

Some depressed patients have abnormally high levels of cortisol in their circulation. The abnormality of resistance to suppression of cortisol production in depressed patients is well known. In one study, 69% of the depressed patients were resistant to the suppressive effects of dexamethasone on cortisol production as compared to 9% of the healthy controls. It has been suggested that this may be a result of decreased concentrations of serotonin and catecholamines in the hypothalamus in depressed patients. Other abnormalities in the hypothalamic-pituitary-adrenal axis have been reported in depressed patients. Patients had a reduced ACTH output in response to infused corticotropin-releasing factor (CRF), but nonetheless, responded with a slightly greater than normal amount of cortisol secretion (Holsboer, et al., 1984). In another study, by Nemeroff and colleagues (1984), the level of CRF-like material in cerebral spinal fluid was elevated in a group of patients with major depression (as classified in DSM-III), but not in groups with schizophrenia or senile dementia (as classified in DSM-III).

Immune Status in Depressed Patients

There have been several studies of immune status in depressed patients. In one of the early studies Kronfol and co-workers (1983) studied 26 patients hospitalized for depression who were drug free for at least two weeks prior to study. Their mean score was 16.3 on the 17-item Hamilton Depression Rating Scale. The group had a reduced proliferative response to both the T-cell mitogens, conA and PHA, as

well as to the T-dependent B-cell mitogen PWM. There was a non-significant trend for more-depressed patients to have lower mitogen responses than less-depressed patients. The authors stated that there was no difference in the responses of those patients who had been taking medications prior to the two-week drug-free period preceding the study, and those who had not, i.e., if there was an effect due to medications, two weeks without drugs appeared to be sufficient to eliminate that effect.

Schleifer and colleagues (1984), in a later study of 18 hospitalized depressed patients, also noted a reduced response to the mitogens conA, PHA, and PWM, as compared with age- and sex-matched controls. These patients were also drug free for at least two weeks prior to the study. Their mean Hamilton Depression Score was 28. The study also noted a decrease in the absolute numbers of peripheral blood B and T cells, although there did not appear to be a change in the relative proportion of B and T cells. In this study, rosetting techniques were used to enumerate B and T cells. Cortisol levels were significantly elevated in the depressed patients (14.05 μg/dL compared with 8.62 μg/dL for controls). The authors noted that the changes observed appeared to be independent of the length of hospitalization prior to assessment of immune status, suggesting that the acute stress of hospitalization was not responsible for their results. It is known that hospitalized patients in general tend to have elevated cortisol levels.

Krueger and co-workers (1984), in a study of six patients hospitalized for depression, examined changes in the lymphocyte subset distributions. The mean Hamilton Depression Score was 26.8. There was a significant decrease in the proportion of

CD4 (helper/inducer) and CD2 (total T cells) as judged by immunofluorescence with monoclonal antibodies. The proportion of B cells, CD8 cells (suppressor/ cytotoxic), and NK cells was unchanged. These findings could help explain the decreased mitogen responses noted in the other studies, since a decreased proportion of CD4 cells would be expected to reduce the mitogen response.

More-recent studies have produced contradictory results as reviewed by Stein and colleagues (1991). Decreased mitogenesis and NK activity is confirmed in some studies, but not in others. A study by Levy and co-workers (1991), found that mitogen response to conA was lower for inpatients with major depression than it was for healthy controls or inpatients with other forms of depression. NK activity and CD4 and CD8 percentages did not differ among the patient groups or their controls. The Hamilton Depression Score was similar for the two patient groups. This would further support the view that depression is associated with lower immune function in only certain subsets of depressed individuals.

Additional studies of bereaved spouses by Bartrop and co-workers (1977) and Schleifer and colleagues (1983) also note decreased mitogen responsiveness in their subjects. In these studies no changes in the levels of cortisol, prolactin, growth hormone, or thyroid hormone were found.

TABLE 3
Immune Changes in Depressed Patients

Study	Changes
B. Linn (1982)	Decreased mitogenesis, decreased proliferation in response to allogenic cells
T. Krofol et al. (1983)	Decreased mitogenesis
S. Schleifer et al. (1983)	Decreased mitogenesis, decrease in T and B cell numbers
M. Stein et al. (1991)	Variable changes in mitogenesis and natural killer cell activity
E. Levy et al. (1991)	Decreased mitogenesis, but only in major depression

Possible Confounding Factors Associated with Depression

Although depression offers an opportunity to study the relationship between psychological status and the immune response, several cautions should be noted. The immune response may be affected by a number of behavioral changes that may be associated with depression. These include heavy drinking, heavy smoking, sleeplessness, dietary changes, and medications.

Drinking can cause decreased NK-cell activity in alcoholics, but these changes are also associated with liver damage and nutritional deficiencies (Charpentier, et al., 1984). Abnormalities in humoral immunity have also been reported. Acute high levels of blood alcohol would be expected to have a temporary inhibitory effect on immune function *in vivo*. In studies of the effect of alcohol on immune function *in vitro*, levels of 0.5%–2.0% alcohol depressed NK-cell and cytotoxic function. The effect depended on the continued presence of alcohol, in that cells which were pre-incubated with alcohol and then washed, regained normal function.

In several studies, smoking has been associated with decreased immune status. A habit of heavy smoking was associated with a modest decrease of CD4/CD8 ratios (Miller, et al., 1982). This was caused by both a decrease in the proportion of CD4 cells and an increase in the proportion of CD8 cells. Neither the total number nor the proportion of T cells changed. The CD4/CD8 ratio returned to normal in heavy smokers who gave up smoking for 6 weeks. The effects in moderate smokers were not significant. In another study, smoking more than 10 cigarettes a day was associated with decreased NK-cell activity and mitogen responses (Hersey, Prendergrast, &

Edwards, 1983). Again, there was an improvement in immune function in smokers who were tested after they stopped smoking. The effects reported have been less pronounced than those observed in depression. Thus, it is possible that heavy smoking could contribute to the observed changes in depression. As far as we know this has yet to be examined.

Sleep deprivation can also lead to decreased mitogen responsiveness. In studies by Palmblad and co-workers (1979), subjects were kept awake for 64 hours. Their mitogen response returned to normal within 5 days. The effect of lesser amounts of sleeplessness are not known.

Changes in dietary habits might also influence the immune response, but again effects are difficult to demonstrate except in extreme situations. It is known that **protein-calorie malnutrition causes decreases in mitogenesis and decreases the CD4/CD8 ratio in children. These changes are accompanied by elevated serum cortisol levels. Deficiencies in single elements such as zinc and vitamins A and E can also depress immune function,** as can high levels of dietary fats, particularly the polyunsaturated fatty acids.

Medications likely to be used to treat depression and their influence on the immune system are not well studied. Antidepressants that affect catecholamine turnover may very well have some effect on immune function. However, the studies of Kronfol and co-workers (1983) and Schleifer and colleagues (1984) in drug-free patients suggest that although the use of drugs should be taken into account, there are significant effects in depressed patients that are independent of medication.

Conclusion

Modern technology has afforded us a heretofore unavailable capacity to study the immune system. Radioimmune assays have also greatly enhanced the ability to measure neuroendocrine mediators. A new and exciting area of research is the exploration of the relationship between psychological, behavioral, and psychobiological factors with the immune system. One way of exploring the relationship is to assess immune function in depressed patients. While such studies are few and must take into account the extraordinary number of factors that have been demonstrated to affect immune function, they suggest that depression is associated with immune suppression. Continued study of this association should elucidate one pathway for the transformation of psychological factors into increased morbidity.

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QUESTIONS BASED ON THIS LESSON

17. So-called memory cells of the immune system:
    A. Originate from erythrocytes
    B. Respond rapidly to subsequent encounters with recognized antigens
    C. Are called T cells
    D. Coat pathogens and help inactivate them

18. Which of the following lymphocytes produce antibody?
    A. Memory cells
    B. T cells
    C. Null cells
    D. B cells

19. The assessment of immune status obtained from the quantitation of the number or proportion of CD4 and CD8 cells:
    A. Involves the release of an isotope, such as chromium, from labelled sensitive target cells
    B. Measures the delayed type hypersensitivity reaction to 5–7 commonly encountered antigens
    C. Is a synonym for the *in vitro* mitogen test
    D. Reveals a major reduction in CD4 cells in patients with Acquired Immune Deficiency Syndrome

20. Cited studies suggest that immune function is diminished in all *except* which *one* of the following conditions?
    A. Major depression
    B. Heavy alcohol intake
    C. Women during pregnancy
    D. Men who are depressed following the death or serious illness of a family member.

Directions in Mental Health Counseling

VOLUME 2 • LESSON 6

AIDS Dementia

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VOL. 2, NO. 6

June 1992

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EDITOR'S NOTE

The most startling fact presented in this lesson is that Acquired Immunodeficiency Syndrome (AIDS) can present itself as a psychopathologic syndrome before any physical manifestations of HIV infection, including seroconversion. The initial presentation in such patients commonly involves symptoms of memory disturbance, depression, mania, delirium, severe psychosis, and personality alteration.

The AIDS virus appears to have direct neurotoxicity. In addition to neurological findings, patients with central nervous system involvement also tend to show forgetfulness, lack of concentration, decreased attentiveness, psychomotor and mental slowness, apathy, irritability, loss of emotional responsiveness, and emotional lability. The severely demented AIDS patient shows little meaningful response, and may exist in an akinetic state, totally indifferent to the environment; the life expectancy for such patients is less than a year.

The therapist or counselor can be the first to encounter the patient. His or her index of suspicion should be raised in high-risk populations, such as homosexual or bisexual men and intravenous drug abusers, and certainly in the presence of an HIV-positive test. Other causes of dementia should be considered in the differential diagnosis. Treatment must aim at various contributing factors from infections to electrolyte imbalances. All professionals in contact with the patient should be knowledgeable in and carefully observe established guidelines to protect against contagion. Staff attitudes toward such patients must be appropriately managed. Consultation with a mental health professional is normally indicated.

Introduction

Dementia is a clinical entity characterized by loss of multiple intellectual functions severe enough to interfere with occupational and/or social functioning. **Memory disturbance is invariably present. Early assessment and diagnosing dementia are essential for the detection and treatment of factors that may arrest or reverse its progress.** Common conditions have included metabolic disorders, general systemic illnesses, neurologic disorders, and central nervous system infections. **Whereas memory disturbance is a hallmark for a diagnosis of dementia, atypical patterns in presentation are frequently seen. For example, in dementias due to infection, depression, personality changes, psychosis, and delirium occur early in the course of illness. Mental and emotional symptoms can mask the subtle early losses of cognition. The disease process may only become obvious only after emergence of focal neurological symptoms or when memory loss is more obvious.**

Historically the dementia from CNS syphilis has also been called "the great imitator" because of the variability in its presentation, which includes depression, mania, delirium, and delusional and hallucinatory states, and because it has been mistaken for functional mental disorders. **Similarly, patients with Jakob-Creutzfeldt disease or subacute sclerosing panencephalitis present with behavioral symptoms that precede the onset of cognitive changes and focal neurological signs by several months. The same pattern is now observed in dementia related to acquired immunodeficiency syndrome (AIDS).**

Mental disorders arising as complications of AIDS have been recorded since the initial description of the disease in 1981. At first, mental and behavioral symptoms were believed to result from complications of systemic infections, from direct effects of tumors, or as psychological reactions to the stigmatizing and devastating effects of the illness. However,

evidence now suggests in some instances mental changes in AIDS patients are a direct result of brain involvement by the disease process. A direct CNS involvement of the virus is supported by findings of cognitive changes that often precede the onset of physical symptoms of HIV infection. Also, the extent of depression, psychosis, disorientation, and memory disturbances in some hospitalized AIDS patients is observed to be disproportionately severe when taking into consideration clinical status and absence of prior mental illnesses. Furthermore, the direct neurotoxicity of the virus is evidenced by the frequent neuropathies in infected patients, the abnormalities observed in brain imaging, the presence of the virus in cerebrospinal fluid, and brain biopsy specimens of patients without physical symptoms of AIDS. In addition, the visna virus, which is similar to the AIDS virus and primarily afflicts sheep, is known to involve both the lymphocytes and brains of infected animals. The incidence of AIDS-related dementia, which is also referred to as AIDS/Dementia complex—or ADC—is now thought by some investigators to be so high that a recent study has estimated it to be present in as many as two thirds of patients dying with AIDS.

TABLE 1
Summary of Classification System for HIV Associated Virus Infections

Group I	Initial infection
Group II	Chronic symptomatic infection
Group III	Persistent generalized lymphadenopathy
Group IV	Other disease
Subgroup A	Constitutional disease
Subgroup B	Neurologic disease
Subgroup C	Secondary infectious disease
Subgroup D	Secondary cancers
Subgroup E	Other conditions

Epidemiology

AIDS dementia was virtually unknown a decade ago and remained so until recently. In 1987, the Center for Disease Control (CDC) recommended a hierarchical staging of HIV infection (see Table 1). Changes in classification provide

recognition of the neurological complications of HIV infection, including the presence of AIDS dementia or AIDS-related organic mental disorders in patients who previously did not meet criteria for AIDS or AIDS-related complex. In the previous CDC classification neurological complications were not specified. **In the new classification, a patient may be diagnosed as having AIDS if a seropositive HIV test is accompanied by features of organic mental disorder, even in the absence of physical symptoms of HIV infection,** such as fever and enlarged lymph nodes.

Although the frequency of AIDS dementia remains unknown, the new classification will undoubtedly increase the reporting of positive cases of AIDS-related organic mental disorders, including dementia (Group IV-subgroup B). Our current understanding of AIDS dementia, however, remains limited, is primarily retrospective, and is derived from observations on the course of illness in hospitalized patients with AIDS, the majority of whom were already seropositive and exhibiting a range of symptoms of dementia. Following seroconversion, the probability of developing AIDS dementia also remains unknown. However, **findings during autopsy show central nervous system HIV involvement in more than 60% of cases. Retrospectively, as many as 38% of those patients had shown cognitive and behavioral changes that met DSM-III criteria for dementia.**

Clinical Manifestations

While there are several unanswered questions on the transmission and course of HIV infections, present understanding on the course of the illness is classified into: primary infection with HIV, the AIDS-related complex (ARC), opportunistic infections, neoplasms, and neuropsychiatric syndromes.

PRIMARY HIV INFECTION:

TABLE 2

Clinical and Laboratory Features of AIDS-Related Complex (ARC)

Clinical

- Fever > 100° F (37.7° C), intermittent or continuous ≥ 3 months, in the absence of other identifiable cause
- Weight loss: 10% of normal body weight or ≥ 15 lbs
- Lymphadenopathy: persistent ≥ 3 months, involving two or more extrainguinal node areas
- Diarrhea: intermittent or continuous ≥ 3 months, in the absence of other identifiable cause
- Fatigue: to the point of decreased physical or mental function
- Night sweats: intermittent or continuous ≥ 3 months, in the absence of other identifiable cause

Laboratory

- Depressed helper T lymphocytes (≥ 2 SD below the mean)
- Depressed helper suppressor ratio (≥ SD below the mean)
- At least one of the following: leukopenia, thrombocytopenia, absolute lymphopenia, or anemia
- Elevated serum globulins
- Depressed blastogenesis (pokeweed, phytohemagglutinin [PHA] mitogens)
- Abnormal intradermal tests for delayed cutaneous hypersensitivity (using multitest or equivalent)

Primary HIV infection presumably presents as an acute illness with fever and resembles influenza or infectious mononucleosis. The incubation period before onset of symptoms ranges from 1 to 7 weeks. Common features of primary infection include fever, chills, malaise, and arthralgia. Patients also report sore throat, swollen glands, vomiting, cramps, and diarrhea. Those symptoms may last from 2 to 4 weeks, and antibodies to the virus presumably develop 3 to 12 weeks following symptom resolution. A more persistent and generalized lymphadenopathy is common after HIV infection. Operationally, it is defined as involvement of at least two extrainguinal nodes. Although lymph node biopsy at that stage is not always informative, in rare instances it has revealed occasional occult Kaposi's sarcoma or B-lymphocyte lymphoma.

AIDS-RELATED COMPLEX (ARC):

Further progression of the infection manifests in the AIDS-related complex (ARC). The distinction between generalized lymphadenopathy and ARC is unclear. ARC is diagnosed in an individual who is infected with HIV and without opportunistic infections but with clinical and laboratory abnormalities (see Table 2). Symptoms include unexplained persistent fever, weight loss, and unexplained diarrhea. Laboratory studies demonstrate depleted numbers of T4 lymphocytes and a marked reversal in the T4:T8 ratio. Leukopenia, thrombocytopenia, and anemia are commonly seen.

OPPORTUNISTIC INFECTIONS IN AIDS:

Progressive immunologic deterioration after HIV infection ultimately results in life-threatening opportunistic infections, neoplasms, or both. In the full-blown syndrome, opportunistic infections follow an aggressive clinical course, with frequent resistance to antimicrobial therapy and a high relapse rate. Commonly seen opportunistic infections include protozoal, fungal, bacterial, and viral infections. Of those groups of organisms, CNS infections are most frequently associated with *Toxoplasma gondii*, cytomegalovirus, *Herpes simplex*, and *Cryptococcus* infections. Treatment duration of opportunistic infections is more prolonged than for most infections, and drug toxicities occur more frequently than in other, noncompromised patient populations.

NEOPLASMS ASSOCIATED WITH HIV INFECTIONS:

Kaposi's sarcoma occurs in approximately half of male homosexuals with AIDS. Lesions of the skin and mucous membrane, lymph node involvement, and lesions of the face and oral cavity are common in patients with Kaposi's sarcoma. The poor prognosis is reflected in a survival period that is usually measured in weeks to months. Other

tumors seen in patients with AIDS include non-Hodgkin's and Hodgkin's lymphoma.

NEUROPSYCHIATRIC MANIFESTATIONS:

Signs of central nervous system HIV infection were thought to usually follow the systemic manifestations of HIV infection. **Increasingly, however, neuropsychiatric manifestations appear as initial and early manifestations of HIV infection. There have been reports of neuropsychiatric symptoms preceding seroconversion.** The process by which CNS infection occurs without systemic involvement being evident remains unclear, however.

CNS manifestations of HIV infection in patients include impairment in cognitive, behavioral, and motor functioning. Frequent early symptoms are believed to include **forgetfulness, lack of concentration, difficulty in recall, and decreased attentiveness. Patients often complain of losing their train of thought in mid-sentence and of being absent minded. Psychomotor retardation and mental slowness are prominent symptoms. Behavioral changes, which mimic a major depressive episode, include social withdrawal, apathy, irritability, loss of emotional responsiveness, emotional lability, and decreased interest in professional and personal activities. Agitation, grandiosity, impulsivity, and visual hallucinations are also observed in some patients.**

In the initial stage of cognitive impairment, common errors on mental status examination include difficulties on numerical tasks (serial 7s) and on tests of short-term memory (recall of objects). However, with progression of CNS involvement, a more global dysfunction is observed. Prior to death, most patients show only rudimentary intellectual and social functioning, with marked psychomotor retardation and verbal and motor responses that border on akinetic states. Hypersomnolence is frequently observed,

although patients are readily arousable. Less frequently, socially inappropriate behavior, confabulation, and full-blown psychosis are seen during the terminal stage.

Neurologic findings during early stages of CNS involvement include incoordination, gait ataxia (the most common), loss of balance, leg weakness, hyperreflexia in the lower extremities with or without extensor plantar responses, tremor, and difficulty in writing. With progression of disease, peripheral neuropathy of varied severity, symptoms of burning, painful paresthesias, numbness, retinopathies (cotton wool spots, hemorrhagic retinitis), optic neuritis, signs of frontal release (grasp reflex being more common), hypertonia, worsening ataxia, fecal and urinary incontinence, myoclonus, and seizures are reported. Although some patients develop hypersomnolence, it is only when systemic complications occur that lethargy and coma develop. Other findings have included signs of pyramidal tract disease (hemiparesis, quadriparesis) and lower motor neuron involvement (paraparesis and monoparesis). **Once severely demented, patients show little or no meaningful response and may exist in an akinetic state, with a wide-eyed stare and indifference to the environment or their state of health. The survival period is usually less than a year,** with death resulting from aspiration pneumonia or complications of systemic opportunistic infection.

A retrospective review of cases of AIDS dementia suggests that in two thirds of patients with AIDS dementia, impaired CNS functioning followed diagnosis of AIDS or ARC. However, in the remaining third, cognitive loss and behavioral changes appeared early and in some instances were observable before all physical manifestations of HIV infection, including seroconversion. The initial presentation in those patients involved symptoms of memory disturbances, depression, mania, delirium, severe psychosis, and personality changes.

Diagnosis

The clinical profile, incidence, and natural history of AIDS dementia remain to be fully characterized. Current information is retrospective but suggestive of behavioral and mental manifestations as early signs of CNS HIV infection in a subgroup of infected patients. **A suspicion of AIDS dementia is raised, however, when cognitive loss accompanied by behavioral and motor changes is seen in HIV-positive cases or in individuals belonging to any of the high-risk group for AIDS, such as intravenous drug abusers or homosexual or bisexual patients.**

The differential diagnosis in AIDS dementia includes: dementia from other organic mental disorders and dementia from functional psychiatric disorders. Proper diagnosis is important in determining the type of workup, consultation, and treatment needed.

AIDS DEMENTIA VS. OTHER ORGANIC MENTAL DISORDERS:

Delirium in AIDS patients can result from systemic complications of toxic/metabolic factors, such as electrolyte imbalance secondary to uncontrolled diarrhea, from infectious processes, or from the use of intravenous drugs or after their withdrawal. When compared with dementia, delirium is rapid in onset, with fluctuations in levels of consciousness, perceptual changes (hallucinations, changes in attention span), and behavioral disorganization. **A clearing in mental status changes will occur with correction of metabolic/infectious processes.**

Depressive syndromes and manic states seen in AIDS patients present as symptoms of dementia and an organic mood disorder without dementia. Cognitive deficits may also be "masked" by the presence of prominent mood changes, with intellectual impairment

becoming obvious only after improvement in mood and behavior. Organic mood disorder in AIDS patients has also been mistaken for functional depression.

Dementialike syndromes in AIDS patients also result from other factors, including meningitis, hypoxemia, and mass lesions such as Kaposi's sarcoma and lymphomas of the central nervous system. Opportunistic infections (toxoplasmosis and *Herpes simplex* encephalitis) can also present with clinical features of dementia, but improvement is probable with appropriate therapy.

Most patients with AIDS are younger adults who belong to any one of the high-risk groups. Although most elderly patients with dementias are diagnosed having vascular or degenerative dementias, recent reports have acknowledged the presence of AIDS in elderly patients.

DEMENTIA VS. FUNCTIONAL PSYCHIATRIC DISORDERS:

Symptoms of depression may be evident with the various emotional stresses that accompany the diagnosis of AIDS. The differentiation of functional from organic disorder is often difficult to accomplish. However, **the presence of cognitive deficits—or of depression that seems disproportionately severe considering the patient's adaptive capabilities—should alert the clinician to an organic component in the presentation.** A period of follow-up and detailed evaluation is often necessary to distinguish functional depression from organic depression.

Brief reactive psychosis accompanying severe stressors are seen in patients with a history of poor adjustment and severe psychopathology, such as borderline personality. The distinction between brief reactive psychosis and organic psychosis is based more on the results of a history and mental status examination. The absence of prior psychotic

episodes and presence of cognitive disturbances, visual hallucinations, fluctuations in consciousness and attention span, severe behavioral disorganization, and abnormal findings on neurological examination are indicative of an organic disturbance. However, the differentiation between an organic and functional psychosis in some patients remains a challenging task.

SPECIAL INVESTIGATIONS:

Routine blood chemistries, CBC, urinalysis, and VDRL are helpful in reaching a diagnosis of correctable metabolic and other infectious sources that contribute to mental changes. An assay of vitamin B_{12}, cortisol, thyroid hormones, and folic acid may reveal other sources of dementia syndromes.

Brain imaging studies may show cortical atrophy that is often accompanied by ventricular dilation in patients with AIDS dementia. In some cases, cortical atrophy has been detected before the clinical onset of dementia. Additional changes that are observed include attenuation of the white matter and focal areas of increased enhancement on magnetic resonance imaging.

Presence of HIV infection is detected using serum assays for antibodies to the virus. Several techniques are used. The ELISA (enzyme-linked immunosorbent assay) is most frequently employed because of its simplicity, low cost, and capacity to be done on a large scale. In high-risk groups, such as practicing homosexuals, the test has a predictive value that approaches 100%. In populations with a low estimated prevalence of AIDS, such as blood donors, the positive predictive value is lower. The major limitation of the current ELISA is a relatively high rate of false-positive reactions, which is nearly 1%. The combination, then, of ELISA with other methods,

including the Western blot test, increases the positive predictive value of the test.

Cerebrospinal fluid examination may reveal the presence of elevated proteins, with a progressive rise in protein levels during the clinical course of the illness. A predominantly mononuclear pleocytosis and oligoclonal IgG banding are also seen in some patients. CSF cultures for HIV are often negative.

The use of neuropsychological tests for early diagnosis of AIDS dementia has shown large variations. The figures for subtle neuropsychiatric manifestations in studies have ranged from 11% to 44% in asymptomatic seropositive subjects, compared with 8% to 15% in seronegative subjects. While those inconsistencies remain to be examined further, in practice subtle neuropsychological findings need to interpreted cautiously. Similarly scores on mini-mental examinations for cognitive capacity are known to correlate poorly with diagnosis of AIDS dementia.

NEUROPATHOLOGY:

At autopsy, less than 10% of the brains of those who had AIDS dementia are reported normal. A diffuse pallor of the white matter and subcortical structures is seen, with relative sparing of the gray matter. Studies have differed in finding a close correlation between clinical status and neuropathology.

Studies using electron microscopy have demonstrated structures consistent with retrovirus particles within multinucleated cells and astrocytes in brain tissue. The association suggests viral replication within the brain, but critical questions remain unanswered. For example, it is still to be determined when in the course of HIV infection and by what route is the brain "seeded" by the virus. It is also not certain as to which cells within the brain are infected by the virus and if differences in the route and site of infection are

attributable to variants of the virus.

Course of Illness

Current understanding of the course of illness in AIDS dementia is based more on information obtained after hospitalization: most of those patients died within weeks or months of diagnosis. Retrospective histories suggest in some instances prodromal features, including forgetfulness, poor concentration, and personality and mood changes, may predate hospitalization by several months or even years. A prolonged and insidious course of AIDS dementia is therefore implied. Prospective studies are currently underway and information from them should soon be available.

Treatment

Treatment of AIDS patients is usually sought for symptoms of depression, dementia, delirium, and denial of illness.

DEPRESSION:

Depression in AIDS patients may accompany or precede symptoms of cognitive decline or present in relation to psychological stressors of a devastating illness. When reactive in nature, depression is not merely a grief response. It often accompanies the uncertainty of diagnosis, guilt about the previous lifestyle, fear of death, exposure of lifestyle, changes in self-esteem, and alienation from family and friends. Psychotherapy focuses on helping the patient recognize and deal with the underlying emotions.

A dynamic relationship may be observed between symptoms of depression, conflicts about how the disease was acquired, and the meaning it might carry for the patient. **Anecdotal reports indicate successful suicide attempts are common, although data on suicide attempts and successful suicide among AIDS patients remain unavailable. Rather than perceiving suicidal thoughts as symptoms of depression, patients may view them as reasonable, considering the social stigma and the fatal course of illness.**

The social support system available to the AIDS patient is also very limited. For example, the contact that family members usually reestablish with the terminally ill occurs less frequently in patients with AIDS. The patients or their families may wish to keep secret the patient's sexual lifestyle, thereby adding to the increased isolation. The patient's lover, fearing infection, may panic, express increased anger and/or abandon the patient. Specific supportive measures and interventions may be needed from a therapist to help family members, friends, and lovers continue their support.

Tricyclic antidepressant medications are frequently used to treat cases of major depression, although information from controlled studies of depressed AIDS patients remains unavailable. A prompt recovery in resistant cases of depression following use of amphetamines, which are administered in doses of 10 mg–40 mg, has also been reported. In those cases, an improvement in cognitive function was also observed.

DELIRIUM:

The principles underlying the management of delirium is similar to that for delirium in other patients. **Neuroleptic medications are useful** in aleviating symptoms of agitation, hallucinations, and psychotic disorganization.

DENIAL:

Even though denial can be an adaptive defense mechanism in patients with a fatal illness, its excessive use may interfere with acceptance of the illness and its proper medical treatment. The liaison model of consultation has been recommended in facilitating ongoing care through the treatment team, as it provides individualized supportive care for the patient. **Countertransference issues may arise while caring for the AIDS patient but differ from counter transference issues in other illness groups.** The fear of contagion—along with superstitions, homophobia, and a tendency to stereotype the AIDS patient—may be fueled by unconscious forces. **Although a component of their fear of contagion is realistic, health care professionals may find help in the form of guidelines that could lessen the risk for transmission of disease.** Similarly, guidelines are also available to minimize transmission of the virus from patients to their partners. Patients, family members, and staff may need to learn how to develop a realistic approach and minimize the risk for contagion. Precautionary measures recommended by the Centers for Disease Control are listed in Tables 3 and 4.

TABLE 3

Risk-Inducing Behaviors for Persons with HIV Antibodies

Abstinence is the only certain method of preventing sexual transmission of HIV. Sexual practices with a partner at increased risk for or known to have HIV infection should not allow exchange of blood or bodily secretions:

- A condom should be worn for all sexual activity.
- Anal intercourse is strongly discouraged.
- Avoid mucous membrane contact with blood, semen, preejaculate secretions, vaginal secretions, saliva, urine, and feces.
- Intravenous drug use is discouraged. If use persists, needles and other injection equipment should not be shared or reused.

TABLE 4

Recommended Precautions for Prevention of Human Immunodeficiency Virus (HIV) Infection in the Clinical Setting

- Routine HIV antibody screening for staff is not recommended. The risk of contracting this bloodborne virus is very low, and it is not spread by casual contact. While the risk of contaminating hepatitis B virus from an infected needle is 6%–30%, an AIDS-infected needlestick carries a less than 1% risk. Precautions are the same as for other bloodborne infections.
- Handle potentially infective needles, scalpel blades, and other sharp instruments with extraordinary care.
- Put disposable sharp instruments in puncture-resistant containers as close as possible to the area of use.
- Do not recap, remove, or otherwise manipulate used needles.
- Gloves alone may suffice for exposure to blood or body fluids. For more extensive contact and invasive procedures, use gowns, masks, and eye coverings.
- Wash hands thoroughly and immediately if accidentally exposed to blood.
- To obviate the need for mouth-to-mouth resuscitation, keep mouthpieces and ventilatory equipment near patients who might require resuscitation.
- Pregnancy does not increase the risk of infection. But because infants may contact HIV infection perinatally, pregnant health care workers should be especially aware of these precautions.
- Wear gloves to clean spilled blood or body fluids. Clean the area with soap and water or household detergent, followed by household bleach.
- Consult a physician if exposed to HIV through a cut, a needlestick, or a splash in the eye or mouth.
- Routine HIV antibody screening of all patients is not recommended.

DEMENTIA:

The mental health professional can play a crucial role in helping AIDS patients structure their daily activities, assist in financial matters, including preparation of a will. He or she can help patients set limits on work and other activities, taking their present mental capacity into consideration.

Neuroleptics are prescribed for managing agitation, delusions, hallucinations, and psychotic disorganization that may accompany dementia. While information on the efficacy of neuroleptics remains unavailable, the principles underlying their general use are similar to those of other dementias. **The presence of target symptoms are favorably associated with response to neuroleptics.**

With progression of dementia and increase in withdrawal, patients often become noncommunicative, so **psychological interventions may be required to deal with difficult staff fantasies and expectations that develop during care of noncommunicative patients.**

While the search for newer drugs in treating HIV infections continues, specific treatments for AIDS dementia remain unknown. **Azidodeoxythymidine (AZT), currently used to treat HIV infections, is known to penetrate the blood-brain barrier and reduce viral replication. The effects of AZT on HIV-induced dementia, however, remain to be established.** In a study of 16 patients with AIDS, no significant effect of AZT on positive CSF viral cultures was found, even though clinical neurological examination revealed improvement in 5 of the 16 subjects. Similar improvement in general mental functioning was observed in patients treated with AZT, including a marked cognitive decline in one patient after discontinuation of the drug. It is also not known if the response seen in patients treated with AZT is a "specific effect" of the drug on HIV in the central nervous system or a nonspecific global response related to general improvement. Because a definitive cure for AIDS dementia is not yet at hand, treatment must be geared toward symptom reduction and supportive care.

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Questions Based on This Lesson

21. Which of the following statements is correct?
    A. A patient with a seropositive HIV test accompanied by features of an organic mental disorder cannot be diagnosed as having AIDS without standard physical symptoms of HIV infection
    B. Autopsy on patients who have died from AIDS show CNS involvement in over 60% of cases
    C. Symptoms of dementia are the earliest evidence of AIDS in all AIDS cases
    D. In the AIDS-related-complex stage of the disease, T4 lymphocytes increase greatly while the T4:T8 ratio remains unchanged

22. During the opportunistic infection stage of AIDS, which of the following is correct?
    A. Relapse rates are high and resistance to treatment intense
    B. *Toxoplasma gondii* and *Herpes simplex* are never causal agents
    C. Antimicrobial therapy is remarkably effective
    D. Cytomegalovirus and *Cryptococcus* are never causal agents

23. Cognitive loss and behavioral changes evidenced by memory disturbance, depression, mania, severe psychosis, or personality changes are reported to appear early and occasionally before all physical manifestations of HIV infection in what percentage of AIDS patients?
    A. 5%
    B. 15%
    C. 33%
    D. 60%

24. The hallmark sign of dementia is:
    A. Hallucinations
    B. Depression
    C. Paranoid delusions
    D. Memory disturbance

Directions in Mental Health Counseling

VOLUME 2 • LESSON 7

Co-Dependence: A New Diagnosis

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VOL. 2, NO. 7

July 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING (ISSN # 1062-0788, USPS # 008-015) is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

In this lesson, the authors explore the concept of co-dependence. The notion itself arises from innovative approaches to the treatment and rehabilitation of patients with substance abuse, including alcoholism. However, it has a long history among those dealing with neurotic interactions in marriages and other forms of pathologic interdependency, as in various "love" relationships.

Rather than seeing the families of addicted or abusive patients as perpetrators, they are viewed as suffering with their own desperate attempt to control their actually or seemingly unmanageable lives, using denial as a major defense maneuver. Whether the family members are so conditioned by their own childhood experiences or by living with exploitive, abusive lovers or spouses, or a combination of both, they tend to become deeply enmeshed in relationships from which they vainly hope to obtain approval and a sense of personal worth. Ironically, although it is the patient who needs the family, the family members experience the interactions as though they need the patient to give them something that the patient is usually quite incapable of giving.

Five co-dependent roles are defined: the enabler, the family hero, the scapegoat, the lost child, and the mascot. Each is designed to cope with dysfunctionality. In assuming any one of these roles, the co-dependent individual becomes restricted and inflexible, minimizes his or her own feelings, tends to become depressed and may at times become suicidal, and runs a risk of becoming abusive or chemically dependent. A need to "be of help to the other" can reach truly pathological proportions. The choice of a career in a health profession can easily be motivated by such a need; when this is so, countertransference issues must be carefully attended to so as to prevent aggravating clients' dependencies.

Introduction

Two trends in contemporary psychotherapy have contributed to a growing interest in the diagnosis of "co-dependence." The first is the renewed emphasis on psychopathological diagnosis in general, which has stressed biological contributions (American Psychiatric Association, 1989; DenBoer, Westenberg, & Verhoeven, 1990) and maintained a strong focus on affective and anxiety disorders (Barlow & Cerny, 1988; Beck & Emery, 1985; Gelder, 1990; Marks, 1987; Mathews, Gelder, & Johnston, 1981).

The second trend that has spurred interest in the diagnosis of co-dependence has been the drug abuse epidemic, which has created a huge industry that treated more than 600,000 Americans for substance use disorders in 1987 (NDATUS, 1987). Substance use disorders, affective disorders, and anxiety disorders are the three most prevalent classes of mental disorder in the United States. Most surprising to many therapists was the finding that 24% of American men and 4.5% of American women (16.4% for men and women combined) met DSM-III diagnostic criteria for substance use disorders during their lifetime, making substance abuse the most common lifetime diagnostic group in the nation.

Whereas substance abuse treatment in the early 1970s was predominantly publicly funded and directed toward heroin addiction and alcoholism, the 1980s saw the emergence of private inpatient treatment for what became widely known as chemical dependence. The major innovation of the private programs was the Minnesota Model, which used inpatient treatment not for detoxification but to overcome denial and to educate patients and their family members to the disease concept of chemical dependence (Office of National Drug Control Policy, 1990). Before discharging patients, the new chemical dependence programs routinely recruited them into the lifelong fellowship of 12-step programs, such as Alcoholics

Anonymous (AA) and Narcotics Anonymous (NA). Family members, having learned that chemical dependence was a family disease and that they needed to work for their own personal "recovery," were referred to mutual-aid programs for relatives of chemically dependent people.

This pattern of practice spread rapidly during the 1980s and became virtually universal by 1990, largely because of the dramatic results it produced when compared with earlier, more traditional medical and psychiatric approaches to treatment. Many of the therapists in the chemical dependence programs—including the professional staff of psychiatrists, nonpsychiatric physicians, psychologists, and counselors—were themselves "recovering" from personal chemical dependence and were members of 12-step programs.

One of the most powerful ideas underlying the disease concept of chemical dependence was that family members suffer from the disease in a way that was parallel to, and as serious as, the way addicted people suffer, and that family members needed help to meet their own needs, not simply to assist the chemically dependent family member. This view changed the earlier definitions of the family role in addiction: traditional family therapy saw the family of the addict as needing and perpetuating the pathological behavior of the addicted person. It viewed the illness of the addict as necessary to maintain the homeostasis of the family: the addict was the victim of the disordered family system (Ellis, 1980; Stanton & Todd, 1982).

In the newer formulation of the disease of chemical dependence many of the family members living with addicts are not unconscious promoters of the pathological behavior but are ill in their own right with an identifiable disease. They, like the addict, suffer from denial as they attempt to cope with their inherently unmanageable lives. Their attempts to gain control of their lives—and the addict—are part of the problem, not part of the solution. These family members, for the sake of their own recovery, need to admit they are powerless over the addict and focus on their own lives, rather than living through the addict. For most family

TABLE 1 —Some Definitions of Co-Dependence

1. ...an exaggerated dependent pattern of learned behaviors, beliefs and feelings that make life painful. It is a dependence on people and things outside the self, along with neglect of the self to the point of having little self identity.

2. ...preoccupation and extreme dependence (emotionally, socially, and sometimes physically) on a person or object. Eventually, this dependence on another person becomes a pathological condition that affects the co-dependent in all other relationships. This may include...all persons who (1) are in a love or marriage relationship with an alcoholic; (2) have one or more alcoholic parents or grandparents; or (3) grew up in an emotionally repressive family.... It is a primary disease and a disease within every member of an alcoholic family.

3. ...ill health, maladaptive or problematic behavior that is associated with living with, working with or otherwise being close to a person with alcoholism (other chemical dependence or other chronic impairment). It affects not only individuals, but families, communities, businesses, and other institutions, and even whole societies.

4. ...an emotional, psychological, and behavioral pattern of coping that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules—rules which prevent the open expression of feeling, as well as the direct discussion of personal and interpersonal problems.

5. ...a personality disorder based on: a need to control in the face of serious adverse consequences; neglecting one's own needs; boundary distortions around intimacy and separation; enmeshment with certain dysfunctional people; and other manifestations such as denial, constricted feelings, depression, and stress-related medical illness.

6. ...a stress-induced preoccupation with another's life, leading to maladaptive behavior.

7. ...a disease that has many forms and expressions and that grows out of a disease process that...I call the addictive process...the addictive process is an unhealthy and abnormal awareness and leads to a process of nonliving which is progressive....

Source: Whitfield CL. Co-dependence—Our most common addiction: some physical, mental, emotional and spiritual perspectives. Modified from a special 1989 issues on Co-Dependence in *Alcohol Treatment Q*, vol 6, 1988.

members of addicts, help to overcome their own part in the disease lies not from traditional psychological treatment approaches but rather from the 12-step programs. It is important, in this view, for the family members to overcome their disease, even if they are no longer living with or relating to the chemically dependent person, since the family member's own disorder continues to have a powerful negative effect on his or her own life.

Definition of Co-Dependence

Co-dependence is a pattern of painful dependency upon compulsive behaviors and on approval from others in a search for safety, self-worth, and identity. Recovery is possible.

This definition was adopted at the First National Conference on Co-Dependency, which was held in Scottsdale, Arizona, in 1989. Whitfield (1988) wrote, "**Co-dependence is a disease of lost selfhood. I define it as any suffering and/or dysfunction that is associated with or results from focusing on the needs and behaviors of others.**" It is a diagnosis that has grown out of the community of sufferers, and it appears to be moving from wide public use to formal diagnostic status.

Originally, the term co-dependence was used exclusively to describe the symptoms or behavior of people living with an alcoholic or an addict. As the term co-dependence gained acceptance, it has come to take on a wider meaning and is increasingly seen as one of many outcomes of living in a family dominated by substance abuse. However, many self-defined co-dependent people are members of dysfunctional families that have not suffered directly from substance abuse (Cermak, 1990).

Co-dependence can be seen as a personality trait or a personality disorder. Cermak (1986) was the first to fit this new diagnosis into the category of personality traits/disorders. In the language of DSM-III-R (American Psychiatric Association, 1987):

> **Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself,** and are exhibited in a wide range of important social and personal contexts....
>
> **The diagnostic criteria for the Personality Disorders refer to behaviors or traits that are characteristic of the person's recent (past year) and long-term functioning since early adulthood.** The constellation of behaviors or traits causes either significant impairment in social or occupational functioning or subjective distress.

Many Americans have been educated about this diagnosis of co-dependence by their own participation in Al-Anon, Alateen, Children of Alcoholics (COA), Co-Dependents Anonymous (CoDA), and other mutual-aid programs. Self-definition of co-dependence has resulted from reading the burgeoning popular literature on addiction and recovery, which has co-dependence as one of the principal topics (Bradshaw, 1988; Schaef, 1986; Subby, 1987; Wegscheider-Cruse, 1985); from "family week," which takes place as part of a Minnesota Model 28-day residential treatment program for chemical dependence; and from co-dependence treatment programs that have been developed, often in close association with private addiction treatment programs, both outpatient and inpatient.

Professionals familiar with such developments in the treatment of CD have sought to bring the diagnosis of co-dependence into the psychotherapeutic mainstream (Cermak, 1986; Cruse, 1991). Whether their efforts succeed or not, all health professionals must become familiar with the term "co-dependence," because it is now widely used and many clients have applied the diagnosis to themselves. At a minimum, practicing therapists should be able to "talk the talk" of co-dependence and use the concept to help those who are dealing with addiction in their families. **At a more ambitious level, the new focus on co-dependence as a formal psychiatric diagnosis of a personality disorder can help mental health professionals think more creatively about diagnosis, focusing more on the persistent and interactive contexts for psychopathology.** It means thinking about personality disorders and diagnoses beyond a biologically based snapshot, as most diagnoses now tend to do.

Arguments Against a Co-Dependence Diagnosis

Not everyone has been persuaded by the public support for the diagnosis of co-dependence. Stanton Peele (1989), author of *Diseasing of America: Addiction Out of Control*, calls co-dependence "...a condition for which groups organized like AA are provided and about which best sellers are written."

Phyllis A. Mullaney (*The Addiction Letter*, 1990), an alcoholic services specialist, says co-dependence is a word that

> ...takes an entire category of people and labels them as damaged goods; strips families affected by alcoholism of their individuality; provides a false sense of self-esteem and worthwhileness that "codependents" wear like a fur coat, fearful of removing it because it is so warm and comfortable, and a self-fulfilling prophecy that sabotages focus on one's self by its very title.

For still others, co-dependence is "the latest good excuse," or a generic term.

Examples of Co-Dependence

The most classic example of co-dependence is the adaptational response of an individual with a behaviorally disordered family member, such as an abusive or chemically dependent spouse. **In order to remain in such a relationship, the co-dependent person must undergo a powerful adaptational, restrictive response. During the co-dependent person's childhood, the patterns of behavior, thinking, and communication (or rather lack of communication) become deeply ingrained.**

Because psychotherapy holds individuals responsible for their behavior, the patterns of co-dependence are often thought to be intrapersonal, becoming so after prolonged exposure to the toxic, dysfunctional setting. That may confirm the implications of the current diagnostic approaches, which locate disorders within

the individual and not with an interpersonal framework (Frances, Clarkin, & Perry, 1984). However, like post-traumatic stress disorder (PTSD), the origins of co-dependence lie not only within the individual but also within the chronic stress of dysfunctional interpersonal relationships.

According to an often-quoted observation attributed to Black (1981), co-dependents "cannot trust, feel, or communicate." As a result, rigid and stereotyped roles are often adopted. Their dependencies on pathogenic individuals are great, and their options for individuality and individual development are constricted.

Roles of Co-Dependents

Co-dependents often take on one or more roles that have been identified as typical among rigid and enmeshed dysfunctional families and in groups as first described by Black (1981), Satir (1972), and Wegscheider (1981). The same roles exist in healthy families, possibly with the same frequency as they do in families dominated by addiction, but in dysfunctional families, the roles tend to be more rigid and result from family needs rather than the needs of the individual. Whether they occur in dysfunctional families or in healthier families, it is often helpful for all involved—including therapists and counselors—to understand those specific roles and to see the limitations on the individual's human potential such rigid adherence to those roles can cause (Cermak, 1990). The more common roles have been termed enabler, family hero, scapegoat, lost child, and macot or baby.

ENABLER:

The role of "enabler" is often played by a spouse who is attached as an adult to an abusive and/or chemically dependent individual. The enabler attempts to be responsible for family function and the relationship by taking over the addicted person's responsibilities and functions, assuming that sharing and mutuality

are impossible. Those roles are often learned in childhood and are continued in adult life by selection of partners who are similar to the parents they knew as children. The result is a diminution of a sense of self separate from the addict and a restriction on personal self-esteem, degrees of freedom, and independent action, particularly relative to the world outside the relationship.

FAMILY HERO:

The family hero, who may be an older child or sometimes a single child in a dysfunctional family, provides a sense of accomplishment and links the family to the outside world. Family heroes often share with enablers the role of family organizer. They are often excellent performers outside the family because of the leadership role learned within the family. However, as a result of the sacrifices made to be co-dependent, they lose their sense of self as well as their abilities to trust, communicate, be in touch with their emotions, and control their relationships. Many are attracted to careers in health care.

SCAPEGOAT:

Family scapegoats have difficulties with their adaptation in the family and may seek recognition outside the family as a result of their loneliness. They often provide a focus for their families' energies because of their difficulties, thereby diverting attention from dysfunctional, addicted, or abusive family members. They, more so than most other co-dependents, identify more closely with the dysfunctional addict, yet they often seem more blameless in their own dysfunction.

LOST CHILD:

The lost child is often a lonely, withdrawn, depressed individual who adapts to the dysfunctional family system through isolation. The demands on the family are thus lessened, but such individuals feel rejected, are unable to relate in interpersonal systems, show poor performance in the outside world, and have a limited ability to trust.

MASCOT OR BABY:

The family mascot or baby survives by being stuck in the family system, by attracting attention, **by being cute and/or funny, and by being a partner, often for life, of other dependent or co-dependent family members.**

Impact of Co-Dependence Roles

The five common themes on the role of the co-dependent are not mutually exclusive, nor are they exhaustive of the maladaptive behavior patterns of co-dependent people. The roles are not fixed over time for any particular individual; instead, these patterns, like the diagnosis of co-dependence itself, are helpful to identify and overcome particular, easily recognizable patterns of maladaptive behavior. They each represent constrictions on the development of the individual's own identity and roles in the world.

The roles adopted during childhood in a dysfunctional family often continue as rigid characterological patterns, the personality disorder of co-dependence, if alternate ways of communicating, feeling, trusting, and relating are not found. **Roles are learned in order to survive as children or as adults in an environment from which escape seemed impossible.** Co-dependent people may be able to switch or share roles, but they are seldom able to move beyond them without help. Their symptoms can be progressive.

Co-dependents often find themselves being caretakers of other troubled individuals, have low self-worth, and tend to repress and minimize their own feelings. Communication difficulties, poor self boundaries, and deficient abilities to manage feelings and emotions are common. They may have physical, sexual, or psychological problems growing out of that pattern of living, such as being **chronically depressed and withdrawn.** Co-dependents may become **suicidal or aggressive** toward others, **may abuse their own children,** or may have recrudescence of symp-

toms of co-dependence as they raise their own children. Co-dependents are at high risk for development of substance abuse or other addictions themselves.

Diagnostic Criteria for Co-Dependence

Based the writings of Cermak, five elements must be present in the diagnosis of co-dependence. They are: 1) **An ongoing investment of self-esteem in the ability to influence and control feelings and behavior—both in oneself and in others—in the face of serious adverse consequences; 2) assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own needs; 3) anxiety and boundary distortions related to intimacy and separation; 4) enmeshment in relationships with personality-disordered, chemically dependent, and impulse-disordered individuals.** The fifth element is the presence of **at least three of the following:** excessive reliance on denial; constriction of emotions, with an abnormal number of dramatic outbursts; depression; hypervigilance; compulsions; anxiety; substance abuse; recurrent victimization from physical or sexual abuse; stress-related medical illness; and remaining in a primary relationship with an active substance abuser for at least 2 years without seeking outside support.

Cermak (in press-*a*) related co-dependence to **the cluster of personality disorders characterized by dramatic, emotional, or erratic behavior, and by anxious or fearful behavior** (clusters B and C), **and to a lesser extent by the cluster of personality disorders characterized by odd or eccentric behaviors** (cluster A). **The core of the personality traits of co-dependence is a distorted relationship to willpower and a persistent sacrificing of personal identity in the hope of having intimacy with a pathological partner.** Co-dependence has many characteristics that are similar to some familiar DSM-III-R personality disorders; however, co-dependence may be distinguished by its unique syndrome characteristics. Recently, Cermak (1990; in press, *b*) has set co-dependence in a broader context of all that happens to adult children of alcoholics and distinguished between onset of co-dependence in childhood and in adulthood.

Differential Diagnosis

The differential diagnosis for co-dependence covers a broad range of signs and symptoms. For example, **co-dependence and dependent personality share many characteristics, but dependent personalities are generally more passive, self-effacing, and docile, whereas co-dependents are frequently (although often unconsciously) active, manipulative, and willful** in their relationships. Avoidant personalities are often **socially withdrawn,** a pattern sometimes seen in the "scapegoat" and "lost child" roles of co-dependence. However, most co-dependents are highly involved in many relationships and appear competent both within and outside the family.

A Dynamic View of Co-Dependence

Co-dependence has a complementary relationship to narcissism. Cermak (in press-*b*) and Freud (1914/1963) related co-dependence to the narcissism of the addicted person, citing the myth of Narcissus, who would not return the love shown him, and Echo, who was condemned to speak only what was said to her. The book, *Alcoholics Anonymous* (the "Big Book"), identifies narcissism as the fundamental problem of the alcoholic with these words: "Selfishness, self-centeredness, that we think is the heart of our problem" (Kohut, 1977). Kohut implicitly supported this common view of members of Alcoholics Anonymous when he focused on the narcissism at the center of the psychopathology of addiction.

The narcissism of addiction exists as a complementary part of a whole family system, with the less visible part being co-dependence. **Co-dependents submerge their sense of self in a quest for survival** in a seemingly inescapable relationship with the addicted person. They come to believe their happiness depends on grandiose—but apparently self-effacing—efforts to remake the addict. In that complementary, dyadic

relationship lies the heart of the disease. For both the addict and the co-dependent, recovery lies in overcoming it. Paradoxically, **only by becoming more independent of each other can the co-dependent and the addict find mature mutuality and love for self and for each other.**

The 12-Step Programs

In discussing modern mental health care, psychiatrists such as Sabshin (1990) pointed proudly to the contemporary focus on biological psychiatry and to the use of potent psychotropic medicines. What has been largely overlooked in contemporary psychiatry and medicine in general is the other powerful revolution going on in the mental health fields: the 12-step movement. Aesculapius, the Greek god of medicine, had two daughters: Panacea, the goddess of medicine, and Hygea, the goddess of healthy living. Modern medicine has rediscovered Panacea. If health care is to thrive and fulfill its mission of helping people in pain, then medicine will have to balance reliance on Panacea with reliance on Hygea. The 12-step programs, and the diagnosis of co-dependence, offer an opportunity to help achieve that goal (DuPont, 1986).

Many mental health professionals remain insufficiently familiar with the 12-step programs, including those dealing with family members affected by someone else's drinking and/or drug use. Khantzian (1981) and Mack (1981), explored the relationships of these programs to contemporary psychodynamic theory. Referring specifically to Alcoholics Anonymous, but with language clearly relevant to all 12-step programs, they concluded that the success of such programs rested in the sharing of problems related to self-regulation.

Two interrelated dimensions of the character defects—those that the co-dependent person brought to the relationship with the drinking and/or drug-using person, and those that developed in reaction to that drinking and drug use—are dealt with in the 12-step programs that are more focused on co-dependence. Al-Anon, Children of

Alcoholics, and Co-Dependents Anonymous offer a unique, workable framework for understanding and overcoming those character defects. Their primary message is to surrender the goal of changing the drinking and/or drug-using person and to focus instead on developing a separate, effective sense of self. Such techniques help the co-dependent person toward effective self-regulation and self-governance (Khantzian, 1981; Mack, 1981).

Treatment Perspective

Not only must therapists and other health professionals be able to make a positive diagnosis of addiction, they must also to be able to diagnose the pathological complementary relationships that surround the addict, co-dependence. Therapists must be able to identify the condition, understand it, and be capable of discussing the syndrome with their clients and their families. Comprehensive treatment of addiction involves helping co-dependents overcome denial of their central role and take the steps necessary to change their own patterns of behavior. **Although traditional individual and family psychotherapy may be helpful in that process, the specific treatment for co-dependence for most poeple is to join a 12-step program and "work the program." Mutual aid groups for families are usually indicated, often with attendance at meetings at least twice a week for many years.** Clients can also be referred to the ever-growing self-help literature on co-dependence, such as the writing of Wegscheider-Cruse and Cruse (1990). Of course, **addicts, who are usually also co-dependent, must never substitute these co-dependence programs for their primary program.** Addicts may profitably use one of these programs later with their primary program to promote their sobriety.

Cermak (in press-*b*) **has distinguished between primary, or child-onset, co-dependence and secondary, or adult-onset, co-dependence. The former often requires intensive and prolonged treatment,** including both mutual-aid groups and psychotherapy; **the latter often responds to less intensive, prolonged interventions** of education, psychotherapy, and mutual aid.

The primary form of co-dependence has a pervasive impact on the process of identity formation. This, in turn, leads to the development of rigid patterns of maladaptive behavior and sparse development of more healthy components of identity. In secondary co-dependence, the affected person responds to the dysfunction of others by heightening latent traits of co-dependence to the level of a personality disorder (Cermak, in press-*b*).

Both mutual aid and psychotherapy can help co-dependents recognize maladaptive character traits and develop new, healthier, and more adaptive behavior patterns. That process of change is facilitated by altering the family dynamics, with a core treatment goal of helping the co-dependent person "detach with love" from the pathological bond with the addict and the addict's narcissism.

Implications for Psychotherapy

There are important implications for psychotherapists and health professionals in understanding and treating co-dependence (DuPont & McGovern, in press). Recognition of the diagnosis of co-dependence forces the treatment community to acknowledge the impact of the 12-step movement in contemporary America—specifically its impact on understanding and overcoming addiction. That acknowledgement will benefit the profession, because the insights and techniques developed in that mutual-aid movement not only are powerful but also have wide applicability. Therapists are often confronted with behaviors in their clients that are both pathological and fixed. Having the 12-step movement as an ally in overcoming such behavioral patterns is an important addition to the therapeutic armamentarium.

Therapists and other health professionals owe it to themselves and to their clients to attend AA, NA, Al-Anon, Alateen, or COA meetings so that they understand this 12-step movement in a direct, personal way. They must be able to refer their clients to these mutual aid programs. The best way to do that is not by giving simple advice ("go to the meetings") but to refer the client to a specific

active and experienced member of a 12-step fellowship so the introduction can be personal. That is especially important for co-dependent clients, because their pride and their usually hidden sense of vulnerability make turning to anyone for help particularly difficult.

Most co-dependents, like most addicts, have an underlying fear that makes the acceptance of a referral to a 12-step program very difficult. Some co-dependents find it easier to accept referral to a professionally run treatment program than to accept direct referral to a 12-step program. Many contemporary chemical dependence treatment programs offer inpatient and outpatient programs specifically for co-dependent people. An organized co-dependence treatment program seems to many co-dependents to be a safer way to begin to deal with their difficult life situations. After they leave such treatment it is easier for them to go to 12-step meetings. This same pattern—professional treatment followed by 12-step work—is common in the treatment of addicts and alcoholics.

TABLE 2
Sources for Information on Co-Dependence

Adult Children of Alcoholics (ACOA)
Central Service Board
Box 35623
Los Angeles, CA 90035

Children of Alcoholics Foundation, Inc.
PO Box 4185
Grand Central Station
New York, NY 10163-4185

Al-Anon Family Group Headquarters, Inc.
PO Box 862
Midtown Station
New York, NY 10018-0862

Co-Dependents Anonymous (CoDA)
Box 33577
Phoenix, AZ 85067

Hazelden Educational Materials
Pleasant Valley Road
Box 176
Center City, MN 55012-0176

Denial is at the heart of both addiction and co-dependence, so the initial referral is both crucial and difficult. Referral to 12-step programs by the therapist or counselor must be done wisely, compassionately, and with determination. Additional information can be obtained from Al-Anon, Alateen, Co-Dependents Anonymous, Children of Alcoholics, and the Hazelden Clinic (see Table 2).

Conclusions

The new diagnosis of co-dependence offers important opportunities for therapists. Co-dependence is a unique personality disorder characterized by a pathological attachment for an addict (***or other dysfunctional individual***) with a search for safety, self-worth, and identity through the control of that individual. It produces constriction in the emotional life and identity of the co-dependent person, making him or her a complement to, and an echo of, the addict.

The recognition of co-dependence is important for understanding and overcoming the dysfunctional family patterns at the root of chronic addiction. The specific treatment for the personality disorder of co-dependence is regular participation in 12-step programs. Specific inpatient and outpatient treatment programs for co-dependence may also be helpful for co-dependent people, just as it is for addicts, in overcoming their fear and resistance to entering treatment. Both individual and family psychotherapy can be useful, and recovery is possible for both the addict and the co-dependent, but they both have lifelong disorders.

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QUESTIONS BASED ON THIS LESSON

25. Which of the following statements is correct?

    A. Patterns of co-dependence are exclusively interpersonal, and removal of the abusive or chemically dependent other cures the problem entirely

    B. The proclivity to be a co-dependent is entirely determined by genetic influences

    C. Co-dependence is often regarded as intrapsychic, but becoming so after prolonged exposure to a toxic, dysfunctional interpersonal setting

    D. None of the above

26. The "Minnesota Model" of drug use rehabilitation:

    A. Directed efforts primarily at detoxification

    B. Emphasized overcoming denial and educating patients and family members to the disease concept of chemical dependence

    C. Rejected the 12-step programs in favor of intensive individual psychotherapy

    D. Excluded family members from participation in rehabilitation programs, thereby diminishing their detrimental influences

27. Which of the following statements is correct?

    A. "Enabler" is a term reserved for those who help addictive or abusive persons overcome their problems

    B. Family "heroes"—who take on leadership qualities in work and academics—are invulnerable to being pulled into being co-dependents

    C. The "scapegoat," who provides a focus of family energies and concerns, can attract attention away from dysfunctional parents or other addicted or abusive family members

    D. The "mascot" engages in a co-dependent role with abusive or addictive family members by persistent, attention-getting antisocial behavior

28. The contemporary view of the family's involvement in substance use disorders stresses that:

A. The family needs and perpetuates the patient's pathological addictive behavior

B. The addict's behavior is essential to maintain the homeostasis of the family group

C. The addict is a victim of a disordered family

D. Family members are ill in their own right, suffering from denial as an effort to cope with inherently unmanageable lives

Directions in Mental Health Counseling

VOLUME 2 • LESSON 8

Pathological Gambling

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VOL. 2, NO. 8

August 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING (ISSN # 1062-0788, USPS # 008-015) is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

With the expansion in opportunities for us to gamble—from the stock market to government lotteries, from Atlantic City to the Caribbean islands—the prevalence of pathological gambling has undoubtedly increased, and with it a serious rise in the personal and familial catastrophes it leaves in its wake.

In some ways, pathologic gambling resembles substance abuse, and the two often go together, but the problem is much more complex than that. Some pathological gamblers are extremely narcissistic; they feel entitled to special privileges, even to the point of defying the rules of chance. Others are covering up loneliness, or anxiety produced by the threat of human intimacy. Still others are expressing rage at some major figure in the past—a demanding and perhaps abusing parent for instance—and, at the same time, their guilt for such feelings. Many enjoy the excitement of flirting with danger. Most manifest the dynamics of habituation and addiction.

There appear to be two major subgroups. The first is the depressive gambler, with his or her negative cognitive style: assuming responsibility for all that has gone wrong in life, being pessimistic about the future, communicating poorly about emotional needs, feeling anxious, guilty, and beset with high expectations of performance which are seldom achieved. The second type is the narcissistic gambler: sociable, verbal, projecting the image of handling life well, but using and manipulating others, displaying little insight into the reasons for failure, desperately in need of stimulation, grandiose, with poorly developed internal value systems.

In treatment, focusing on the gambling behavior alone appears to be insufficient. A broader approach that targets intervention to the multiple needs and complex dynamics of clients is necessary. This may include individual and group therapy, support groups, and even, at times, inpatient care.

Definition

In DSM-III (American Psychiatric Association, 1980), pathological gambling is classified as a disorder of impulse control and is defined as "a chronic and progressive failure to resist impulses to gamble and gambling behavior that compromises, disrupts, or damages personal, family, or vocational pursuits." Pathological gambling may also be seen as an addictive behavior, and therapists treating pathological gamblers have long noted its addictive quality (Adler & Goleman, 1969; Moran, 1975; Tyndel, 1963; Zimmerman, Meeland & Krug, 1985). Pathological gambling and substance abuse often occur together, both in identified clients and in their biological families (Ramirez, et al., 1983). Gamblers have personality profiles similar to substance abusers (Graham & Lowenfeld, 1986; McCormick, et al., in press). A phenomenon comparable to tolerance develops as the pathological gambler increases the amount and intensity of gambling. By the same token, the gambler reports a short-term "withdrawal syndrome" following the cessation of gambling that is similar in symptomatology to that of the substance abuser (Wray & Dickerson, 1981; Custer, 1984). Further underscoring the similarity of pathological gambling to other addictive behavior, the DSM-III-R sets criteria for pathological gambling that are basically identical to those for substance abuse, except for the physiological effects of the exogenous substance.

Prevelance of Pathological Gambling

A study by the U.S. government's Commission on the Review of the National Policy Toward Gambling estimated that in 1976 there were over 1.1 million pathological gamblers in the United States. It is likely that the number has continued to climb as more people are exposed to increased opportunities for gambling. The number of places where casino gambling has been legalized increased

significantly in the past 20 years. Sports betting, which alone is estimated to exceed $70 billion annually, has expanded to include legalized off-track betting. Publicly administered lotteries in the United States are now offered in over half of the states of the union, with wagering exceeding $10 billion annually. All these increases are accompanied by tremendous media exposure, promoting gambling as a recreational option or financial salvation. Lotteries invest large sums in paid advertising, and the most recent super-lottery winner becomes front-page news on a recurring basis. More subtle forms of gambling are also increasing. The volatile commodities and futures markets, as well as speculative investing in the stock market, are options for the upper- and middle-class gambler.

Personality Dynamics of the Pathological Gambler

The earliest writings on the personality of the pathological gambler are to be found in psychoanalytic literature. Freud (1975) analyzed the personality of the novelist Dostoevsky, a heavy gambler in the casinos during the nineteenth century, and found similarities between pathological gambling and the compulsive neuroses. It seemed that gambling was used to cope with recurrent anxiety states related to his preoccupation with the sudden death of his father when the novelist was 18 years old. Freud suggested that a parent figure who was perceived as demanding and punishing in the gambler's early life was hypothesized to produce guilt and depression.

Fenichel (1945) stressed the narcissistic qualities of the pathological gambler: he or she feels entitled to special privileges, expecting to be exempted even from the rules of chance, and has unrealistic faith in his or her ability to overcome the odds. Fenichel also noted the parallel between the mood swings of the gambler and the win-lose cycle of gambling.

Bergler (1958) synthesized his observations of the more than 60 pathological gamblers he treated and provided the basis for modern concepts on the disorder. He noted that **gamblers seem to search for a "pleasurable-painful" tension level that is more important than winning itself,** and he focused on the gamblers' anger and aggressive impulses. This **anger generates guilt, since at an unconscious level the anger is directed at the parent who previously had had the role as the socializing influence in the child's development.** Bergler felt that gambling, with its inevitable losses, satisfies a masochistic need for **self-punishment.**

Greenberg (1980) noted the **overconfidence, impatience, and even grandiosity** of some gamblers but considered this to be **a cover for loneliness and anxiety produced by the threat of intimacy. Gamblers are preoccupied with the present. They have come to value competition and material success highly but are driven by needs that cause them to demand too much too soon. They narcissistically ignore the reality factors necessary for enduring success.**

In a similar vein, Rosenthal (1985) hypothesized that gamblers build an illusion of omnipotence in order to defend against a deep sense of helplessness. Gamblers **flirt constantly with danger in order to test their self-worth and power.** Rosenthal suggests that the gambler uses the primitive defenses of denial, projection, and splitting. Bettors dichotomize themselves and others, uncertain of their own boundaries and identities. They are forced to rely on the value system of others, and consequently **seek continual approval. Intimacy is difficult,** so arousal and physical gratification are used as substitutes.

In a sociological study of the gambler, Lesieur (1977) offers insight into the personality dynamics of the gambler. Observing that gamblers are preoccupied with wagering to the exclusion of other activities, he argues that **as the behavior progresses, gamblers become increasingly unable to see that there may be rational alternatives to gambling.** They enter a spiral of decreasing options and come to see gambling as the solution for their problems rather than as the source of them.

Subtypes of Pathological Gamblers

There is significant variation within the diagnostic classification of pathologic gambling. Consequently, establishing subtypes has some clinical utility. Two major subtypes emerge—the depressive gambler and the narcissistic gambler.

THE DEPRESSED GAMBLER:

Depression has been established in a substantial portion of pathological gamblers entering treatment (McCormick, et al., 1984). While for some the depression seems to be primarily situational, for a significant number it is a lifetime pattern that precedes their gambling. For many, there is a life history of significant trauma (Taber, McCormick, & Ramirez, 1987). A history of child abuse, often at the hands of an alcoholic parent, is remarkably common. Seriously depressed gamblers exhibit a cognitive style that feeds the depression, and tends to exaggerate their responsibility for negative life events. When things go badly they generalize the results of a setback in one portion of their lives, believing that they are total failures. They are pessimistic about future events and interpret the past in a most negative light.

Depressed gamblers often display an avoidant personality style. They tend to communicate very little about their emotional needs and will minimize the intensity of their affect. Symptoms of anxiety disorders may be present, including intrusive thoughts and nightmares, but they are seldom volunteered. Guilt and remorse are intense, but they do little to change the repetitive gambling behavior. Seriously depressed gamblers tend to minimize their accomplishments and perceive themselves to be underachievers.

They will often go through periods during which they display responsibility and control. They may have stable work or family histories and, even in the midst of an impulsive gambling spree, may display some capacity for control. Depressive gamblers generally have strong—in fact, overly rigid—value systems, and their

histories often reveal a strong, hard-driving parent whom the client was never able to satisfy.

THE NARCISSISTIC GAMBLER:

Narcissistic gamblers are outwardly sociable and verbal. They project an image of being able to manage things, but—despite fleeting successes—their accomplishments seldom match their claims. They focus primarily on their own needs, and although they can be charming, people who attempt to form relationships with them tend to feel used and manipulated. Narcissistic gamblers feel entitled to special consideration and treatment, making unreasonable demands for attention and displaying exhibitionistic tendencies. They display little insight into the reasons for their failures and tend to project blame for their losses onto others or factors outside their control (e.g., the market was in a period of unpredictable adjustment). Narcissistic gamblers are more likely to engage in forms of risk-taking that have high visibility and stimulation, such as stocks, commodities, and high-stakes casino gambling. Although their behavior may, in fact, be an attempt to compensate for deep-seated feelings of emptiness and inadequacy, they have little awareness of any such feelings or of dysphoria. Probing will often reveal some awareness of the negative feeling that a lack of stimulation produces for them, and they will acknowledge being easily bored and having a "need" for excitement.

Narcissistic gamblers may have a poorly developed internal value system. They attempt to read the expectations of others and attempt to project values that they believe will be accepted and thus attain their goals. The lack of clear internal values and beliefs may contribute to their feelings of emptiness.

The Addictive Cycle

The addictive cycle for the pathological gambler reveals complex interaction of biological and environmental factors that puts the gambler at risk for the disorder.

The biological/hereditary factors might include **an unusually large need for stimulation,** an endocrine disorder, or a catecholamine imbalance that aggravates dysphoria. The environmental factors could include **inadequate early socialization experiences and traumatic experiences.** Then the person is exposed to gambling as a recreational option. **The high-arousal gambling experience provides excitement and, in the case of the depressive gambler, relief from the ongoing dysphoria. Pathological gamblers report that while they are gambling they experience euphoria and a marked change in mood.** They are able to focus all their attention on the gambling experience and are thus relieved of all awareness of their life problems.

Once exposed to gambling as an option, **the return of a need state reactivates the addictive cycle.** In the case of narcissistic gamblers, the need state may be the **boredom** reported by the bettor or the **emptiness** and **fears of loneliness** hypothesized by personality theorists. While in the need state, they perceive the options available for relief, but **as the addiction progresses and intensifies, their perception of the available options diminishes.** In choosing gambling, the pathological gambler finds temporary relief and—in some cases—euphoria. **Such relief may have its biological underpinnings in the activation of the hypothalamic-pituitary-adrenal axis** by the high-arousal gambling behavior. That activation may, in turn, stimulate a modulating endorphin system that is intended to control the activation (Gold & Rea, 1983). In the depressed gambler, catecholamine and endocrine changes involved in the activation of these systems may have an antidepressant effect.

However, for psychological and perhaps physiological reasons the relief is temporary. Losses are inevitable and they compound the gambler's difficulties. **Lying, stealing, or embezzling are used increasingly to provide the money necessary to support the gambling behavior. Family and friends are further alienated.** The gambler is left feeling that he or she is more of a failure and, in the case of the depressive gambler, more guilty and dysphoric. At the physiological level, the constant arousal and activation lead to compensatory adjustments in biological systems which

the gambler may experience as "withdrawal." These adjustments may also raise the threshold of arousal necessary to experience mood changes, an effect comparable to tolerance.

The rebound need-state may then be more intense than the state that originally precipitated the gambling. The addiction intensifies and the gambler becomes increasingly desperate in his or her search for the "action" and the psychological relief it provides.

The Clinical Management of the Pathological Gambler

Case management must be based on a thorough assessment of a variety of psychological, environmental, and biophysical variables. When interviewing gamblers the therapist or counselor must **bear in mind that, as with other addictions, denial, minimization, and rationalization are likely. Gamblers may relabel some of their gambling behavior, referring to it as "investing" or their "profession."** Gamblers' stories may be so rich as to be seductive. **They will tend to concentrate on finances and see money as both the problem and the solution** (A.P.A., 1980). A **thorough history** of the nature, frequency, and intensity of the client's gambling experience must be obtained. It is also important to **assess the degree to which the gambling behavior affects major elements in the client's life,** including family and vocation. Equally important, but often more difficult, is the **assessment of the gambler's subjective experience during the anticipation phase of gambling and his or her progression to actual gambling behavior.** It is often helpful to encourage the use of analogies or metaphors to describe these subjective experiences.

Pathological gambling is a stressful life-style, and consequently there is a **high incidence of cardiovascular and stress-related physical disorders.** The assessment of psychosomatic conditions also provides supportive data for the assessment of

personality style. **Hyperactivity is common** in gamblers (McCormick, et al., 1984), and it is therefore important to consider the possibility of endocrine dysfunction. **Undiagnosed hypothyroidism can contribute to the gambling cycle in a small but clinically significant subset of cases.**

A thorough history should track significant life events, particularly those of a traumatic nature, as well as the development of interpersonal relationships. Having the gambler complete a written autobiography can be especially helpful in this regard (Adkins, Taber, & Russo, 1985). The client's history of **mood shifts and the development of internalized values** should also be probed, with special emphasis on **the development of a competitive outlook toward life.** Other addictive behavior may contribute to gambling or recur with it over the course of the client's life. Again, **the gambler will tend to underestimate the severity of those addictive behaviors such as substance abuse and sexual promiscuity.**

Personality testing can be useful in understanding the dynamics of the client and in subtyping the disorder. Work to date has primarily focused on the **Minnesota Multiphasic Personality Inventory (MMPI)** (Bolen, Caldwell, & Boyd, 1975; Graham & Lowenfeld, 1986). **The depressive gambler shows high elevations on scales measuring depression and anxiety. Elevations on scales measuring impulsivity and hyperactivity, while they may be high compared to a normal sample, are moderate when compared with other types of pathological bettors. The depressive gambler may also show elevations on scales measuring social introversion, contradicting the stereotype that all gamblers are gregarious. The California Personality Inventory (CPI), which measures personality dimensions of a nonpathological nature, can also be of unique value.** The CPI provides measures on personality dimensions which are directly relevant to treatment, such as **responsibility, ego control, and self-control** (McCormick, et al., 1987).

In the assessment process, it is also valuable for one to understand the nature of the addictive cycle for each particular gambler. **Cues that seem to trigger the cycle can**

include internal phenomena, such as vague feelings of uneasiness, boredom, or anxiety, and external cues such as sights, sounds, or angry interchanges with family or friends. Potentially competing responses to gambling behavior should also be noted. They may include functional behaviors that also tend to take on an addictive quality—for instance, many pathological gamblers are workaholics when not gambling.

Information on the treatment of pathological gambling is limited. Bergler (1958) claimed a 75% success rate with the gamblers he treated but provided no clear data on the criteria used to define success or the severity of the clients' problems. A variety of behavioral approaches has been attempted, including one by Barker and Miller (1968) that reported favorable results for three patients treated with electric-shock aversion therapy. In a subsequent report that compared the results of aversion therapy with 10 patients against the results of imaginal desensitization for 10 other patients (McConaghy, et al., 1983), the aversion therapy was shown to be unsuccessful as measured by a one-year follow-up. Some modest improvements were seen among the desensitization subjects, however. Greenberg and Rankin (1982) reported on 26 male compulsive gamblers at an outpatient clinic who were treated with a variety of behavioral methods, but results were again modest. **The less-than-dramatic results achieved with behavioral methods may indicate that focusing on the gambling behavior itself is insufficient.** A broader approach that targets therapeutic interventions at the multiple needs of the client are likely to be necessary.

Inpatient programs for severe pathological gamblers have become more common in recent years, and many are modeled after the rehabilitation programs available for substance abusers. One of the oldest and best-studied is the program at the Brecksville Veterans Administration Medical Center in Ohio (Russo, et al., 1984). This program provides a highly structured treatment approach and uses the inevitable conflicts that the participants have with the rules and expectations of the therapeutic environment as "grist" for the therapeutic mill. A variety of modalities are available, but **the primary thrust of the program is group therapy and peer counseling.**

In **peer counseling** a recovering pathological gambler provides support, role modeling, and—when necessary—confrontation. The peer counselor can model assertive action, provide advice and encouragement, and be effective in confronting the gambler's denial and in breaking through the gambler's deflection of responsibility and blame to others. Gambler's Anonymous, known as G.A., has a long history of successful intervention with many pathological gamblers. Its step-work system for spiritual or psychological growth concretely focuses the client away from gambling behavior and toward the psychological steps necessary for effective recovery.

The concept of "serenity," which the self-help groups encourage, has a number of positive aspects for the gambler. Gamblers tend to overvalue material goods and accomplishments, to concentrate on external stimulation and confirmation, and to have difficulty accepting and rewarding themselves for moderate, less-than-spectacular accomplishments. The concept of serenity, which urges self-acceptance and highlights the value of everyday personal accomplishments, is a useful method for the gambler to conceptualize the understand changes that need to be made in all these areas.

The therapist should bear in mind, however, that **G.A. meetings vary considerably. They may not have the degree of structure and discipline characteristic of Alcoholics Anonymous meetings,** so it may be important to prepare some clients for the particular G.A. group they will encounter. On balance, the G.A. experience is almost always a positive one. Preparing clients for those aspects that may be less tolerable for their particular personality can help ensure that they won't use the aspects of the experience they find unpleasant as an excuse to abandon the whole experience. **Family members are also strongly encouraged to join a Gam-Anon group.** It focuses on their feelings and provides them with the guidance and support necessary to cope with living with a pathological gambler and often to change their pattern of enabling the gambler's behavior.

Group therapy is the other cornerstone of the program. Therapy is conducted by mental health professionals familiar with gamblers and addictions in general. Pathological gamblers generally tend to be highly verbal, so the therapist must keep the process in focus. While the peer group sessions may begin working through the gambler's denial, it is in group therapy that the process of supporting and working through the pain of change can occur (Taber & McCormick, 1987). In therapy the gambler may reveal his or her irrational beliefs. They include the delusion that, if you keep on betting more and more, eventually you have to overcome your losses, and irrational beliefs about the self that are similar to those of depressed or narcissistic individuals in general. One such belief common among gamblers is that you can only be cared for if you are bestowing large monetary presents on those around you. The narcissistic gambler may have irrational beliefs about his or her gambling "skills" or "system" that border on grandiosity.

An integrated inpatient approach has been shown to provide good results for many gamblers entering treatment (Graham & Lowenfeld, 1986). In one outcome study, 56% of persons followed in the community 6 months after treatment were totally abstinent (Taber, et al., 1987). Subjects in this study had been given a battery of psychological measures on entry into treatment, and those with a depressogenic cognitive style were significantly less likely to be abstinent at follow-up. These individuals, who tended to attribute the cause for negative events to internal reasons and to generalize the negative event to other areas of their lives, were apparently less able to cope effectively with the inevitable setbacks that occur during the recovery process. In general, psychopathologic symptoms subsided with abstinence, but in some cases depression and anxiety continued at high levels despite such abstinence. This further underscores the therapeutic utility of evaluating the independence of the dysphoria and the gambling and adjusting treatment accordingly.

Clearly, **not all clients require a highly structured inpatient approach.** Many do very well in G.A. alone. Individual therapy can also be effective with the pathological gambler. The therapist or counselor, however, must strive to provide structure for the gambler. Education on the realities of pathological gambling, including helping the client to be clear on what gambling is, and confrontation of denial and other defenses early in the process is critical. G.A. can be used to provide additional assistance in these areas. The therapist can also effectively intervene with the irrational beliefs of the gambler. **Cognitive therapy, with homework assignments that extend the therapy outside of the treatment sessions, is a potentially effective approach.** Once abstinence is obtained, longer-term therapy can focus on underlying depression and identity conflicts.

Reports on the use of pharmacotherapy to treat the pathological gambler are sparse. **Moskowitz** (1980) **cited four cases in which lithium provided improvement.** This is likely to occur primarily when case assessment indicates significant hypomania. **Antidepressant medication can be of use in cases where the depression is documented to be recurring and long-standing.** The strong tendency for gamblers to establish other addictive behaviors must be considered when psychoactive medication is prescribed. Suicidal behavior is also very common in the depressed gambler (McCormick, et al., 1984) and needs to be addressed in the prescribing process.

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QUESTIONS BASED ON THIS LESSON

29. In 1976 it was estimated that the number of pathological gamblers in the United States was approximately:
    A. 250,000
    B. Slightly over 1,000,000
    C. Slightly over 5,000,000
    D. 10,000,000

30. The pathlogical gambler persistently exhibits:
    A. Profound lack of confidence
    B. A strong sense of reality
    C. Aversion to risk
    D. An ongoing search for the approval of others

31. Which of the following statements regarding the depressed pathological gambler is correct?
    A. He/she is rarely, if ever, depressed at the time of seeking professional help
    B. Depression is entirely situational, a consequence of the gambling behavior pattern, and never precedes the ill-fated activity
    C. A history of child abuse is quite common
    D. He/she is able to communicate freely and well about emotional needs and readily acknowledges prior accomplishments

32. Which of the following statements regarding pathological gamblers is correct?
    A. They manifest an unusually low incidence of cardiovascular and other stress-related physical disorders
    B. They tend to undervalue material goods and accomplishments
    C. Group therapy is clearly contraindicated in their rehabilitation
    D. There is some evidence that the use of lithium or antidepressants may be valuable in managing underlying mood disorders

Directions in Mental Health Counseling

VOLUME 2 • LESSON 9

Depression and the Elderly

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VOL. 2, NO. 9

September 1992

182

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DIRECTIONS IN MENTAL HEALTH COUNSELING (ISSN # 1062-0788, USPS # 008-015) is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

As the population of the country ages, the need for psychiatric care in the elderly becomes progressively greater. It is estimated that the prevalence of severe depression after age 65 is about 2%–3%, and for mild depression 3%–4%, with men being no less subject to this condition than women. Untreated major depression in the elderly has been shown to lower life expectancy and provide a greater risk for cardiovascular disease. Differential diagnostic issues are important. Excessive crying, for example, may be a sign of a mood change but may also result from neurological disorders. The need to distinguish between cognitive changes associated with depression and those announcing the onset of dementia is well known. Psychotherapy, pharmacotherapy, and due attention to family and social issues must be effectively integrated. In managing psychotic depression, combining heterocyclic antidepressants with major tranquilizers or using ECT appear to be methods of choice. Concomitant medical conditions require appropriate care. Successful handling of grief may reduce the risk of more serious depressive illness.

Overview

Affective disorders constitute the most commonly encountered psychiatric illness, with estimates among elderly hospitalized and community-dwelling residents of 10%–65% (Jenike, 1989). As many as 20%–35% of elderly patients with concurrent medical illness are reportedly depressed (Moffie & Paykel, 1975; "Psychiatric illness," 1979). Gurland (1976) more conservatively estimated the prevalence of severe depression after the age of 65 years to be about 2%–3% and the rate for definite but mild depression 3%–4%. In most studies, women tend to have higher rates of depression than men in almost all age groups below age 65; over that age, however, the frequency of depression in men increases so that the difference in rates tends to lessen or even reverse (Gurland, 1976).

Those over age 65 account for about 11% of the U.S. population but commit about 25% of all suicides (Busse & Pfeiffer, 1977; Sendbuehler & Goldstein, 1977). White men over age 65 have a suicide rate four times that of the national average and twice that of women in the same age group (Resnick & Cantor, 1967).

Depressed elderly patients are often malnourished and agitated for months or even years (Jefferson & Marshall, 1981); untreated major depression lowers life expectancy and is associated with a greater risk for cardiac disease (Tsuang, Woolson & Fleming, 1980). Depression in the context of a dementing illness can present special challenges.

In view of the effective therapies available for depression, it is particularly crucial to reach a diagnosis and proceed with treatment. In this lesson, we will review some of the diagnostic complexities and nonpharmaceutical treatments for depression as well as provide an overview of pharmacologic approaches.

Diagnosing Depression

Although sadness is common in the elderly, it is unclear how normal sadness and clinical depression are related (Klerman, 1976). Clinicians also do not agree on the full

range of affective phenomena to be diagnosed as pathological. **In older age groups, the depressed client may not admit to the symptoms of depression itself but rather to the accompanying anxiety, somatic or hypochondriacal symptoms, or loss of concentration and difficulty with memory** (Georgotas, 1983). **The elderly may present with various clinical pictures such as chronic pain, multiple somatic complaints, or even dementia (pseudodementia)** (Fogel & Kroessler, 1987).

Although some elderly depressed persons present atypically, many can be diagnosed according to DSM-III-R criteria. **A clue to recognizing depression in the elderly is the presence of multiple somatic complaints in several body systems. When a client's complaints do not fit a recognizable pattern or when chronic pain is a component, depression should be suspected.**

Crying in Medically Ill Clients

Crying in medically ill clients is not uncommon, and, since it is not always a manifestation of depression, may present a diagnostic dilemma. In an effort to clarify the relationship of crying to depression in the medically ill—and suspecting that many "depressed" crying patients would actually be suffering from **neurologically induced emotionality**—Green and associates (1987) evaluated hospitalized patients who were referred to the psychiatry consultation service with a primary symptom of crying. They found crying was often due to the presence of **neurologic disease, which was vastly underestimated by the referring physicians. The majority of those for whom crying was the prominent symptoms had a psychopathologic disorder plus a medical or neurologic condition that did, or in theory could, contribute to a tendency to cry easily. Examples include individuals withdrawing from alcohol or taking steroids.** A third of the prominent criers had neurological disorders and no discernible psychopathologic disorder.

It is not uncommon to see crying patients in the hospital, and it is clear from that report that effective therapy for patients who cry depends on proper identification of the cause of crying. Many suffer from structural or metabolic brain dysfunction and not from a primary psychopathologic disorder. In fact, neurologic disorders were

more likely than psychopathologic disorders to produce crying. Bilateral cerebral disease was the most common neurological cause. **Pseudobulbar palsy from stroke-related bilateral corticobulbar lesions, motor neuron disease, or multiple sclerosis are among the classic syndromes in which pathological crying is seen.**

Since we typically associate crying with sadness, family members may misinterpret the crying in a client with a neurological or dementing disorder to be a manifestation of depression. But they are usually **easily convinced that the client is not depressed when it is pointed out, by questioning the client in front of family members, that the client is not, in fact, feeling sad while crying.**

Choosing to Die

One might think it quite natural for the terminally ill to want to die. However, Brown and associates (1986) noted the prevalence of depression and suicidal thinking among terminally ill people has become an important topic. Organizations such as the Voluntary Euthanasia Society in the United Kingdom and the Hemlock Society in the United States were founded on the basic assumption that people facing serious life problems—especially those with a painful, disfiguring, or disabling terminal illness—should be given encouragement and assistance in thinking of suicide as a rational solution. Brown and colleagues found a paucity of data on the mental state of those who are terminally ill, however.

Clinicians frequently encounter clients who wish to die. **Suicidal thinking is a DSM-III-R criterion for depression but does not by itself justify a diagnosis of depression. In trying to evaluate the presence of depression in the terminally ill who wish to die, Brown and coworkers (1986) noted special difficulties in evaluating the DSM-III-R criteria, because anorexia, weight loss, insomnia, reduced energy, and concentration difficulties are also common features of chronic debilitating disease.** They administered the Beck Depression Inventory, a self-assessment instrument, to terminally ill patients and performed a short interview to evaluate whether clients wished to die and whether they suffered from depression. All 44 subjects had terminal cancer except one, who suffered from severe hypertension.

Each who desired death was found to be suffering from severe depressive illness, and of the 44, 11 were severely depressed. Of those not diagnosed with clinical depression, none had thoughts of suicide or wished death would come early; suicidal thoughts and desire for death were linked exclusively to the presence of depression. Clients with terminal illness who were not mentally ill were no more likely than the general population to wish for premature death. If a terminally ill person wants to die, clinical depression should be strongly suspected. Aggressive treatment of the mental disorder should be attempted in order to maximize the quality of the life remaining.

Evaluation and Differential Diagnosis

Fogel and Kroessler (1987) recommended that the therapist not presume the client's medical problems are stable or even fully known and instead request a thorough physical examination, neurological examination, and laboratory work-up. A systematic, structured cognitive assessment is invaluable in diagnosis and management, provided that results are properly interpreted. Beyond the identification of gross delirium and dementia, cognitive assessment identifies clients with mild-to-moderate dementia or those with focal neurological lesions that may interfere with psychotherapy or adherence to medical treatment regimens. Cognitive deficits found during neuropsychologic screening of those who are actively depressed should serve only as a baseline and not be used for the definitive diagnosis of dementia. Depressed clients with cognitive impairment should be retested after maximum remission of their mood disorder.

A meticulous neurological exam, for example, may uncover parkinsonism, tardive dyskinesia, or previously unsuspected deficits in higher cortical function (Fogel & Kroessler, 1987). Gait disturbances may be the primary physical sign of an organic illness that could range from hypothyroidism to normal-pressure hydrocephalus. Earlier laboratory tests should be reviewed, and claims that laboratory tests are "essentially normal" should not be taken at face value. For example, hypothyroidism cannot be ruled out without obtaining a TSH (thy-

roid-stimulating hormone) level. A consistently low B_{12} level does not conclusively rule out neuropsychiatric B_{12} deficiency.

Fogel and Kroessler (1987) also advise a **high level of suspicion for drug toxicity and drug interaction.** When available, drug levels should be obtained: **one cannot assume that the physician who prescribed the medication is familiar with its neuropsychiatric side effects.** When the contribution of a drug to the psychological syndrome is in doubt, it should be discontinued if possible and a less psychotoxic substance found. When it has been determined that a client is depressed, it is necessary to rule out both medical and psychological causes (Jenike, 1989).

Cognitive Changes Associated with Depression (Pseudodementia)

When an elderly person appears demented, special care is required to rule out depression. Initially, family members should be asked if they have observed any of the DSM-III-R symptoms in the person. Complaints of poor memory may accompany functional depression and disappear after treatment. Conversely, very early organic brain dysfunction such as Alzheimer's disease, with a gradual decline in cognitive functioning, may produce a reactive depression that can lead to further cognitive impairment.

The term pseudodementia is often used to describe depression-related cognitive deficits that are reversible with appropriate treatment of the affective illness. Probably "pseudo" is not a helpful term, because the cognitive changes are in fact real and demonstrable, but the terminology is so ingrained in the literature that it will be with us for some time. Lack of effort on the part of depressed clients is often observed by clinicians, who note clients' increased dependency, indecisiveness, and avoidance of responsibility as part of a general picture of motivational change.

Depressed clients perform poorly on a number of motor performance tasks, and when retested after adequate treatment of depression, their performance often improves strikingly. Clients with depression have also been reported to show

deficits in memory and conceptualization. However, some aspects of memory ability are reported to be preserved in those who are depressed. Memory tasks that impose structure on the to-be-remembered items are performed relatively well by depressed patients (Jenike, 1989).

Some speculate it may be unreasonable to hypothesize basic memory deficits in depression: the most parsimonious explanation of available data would be one based on a single deficit in the central motivational state (Cohen, et al., 1982). In other words, general deficits in motivation, drive, and attention may account for the clinical and experimental deficits found in those suffering from depression.

A number of authors have attempted to identify clues that would separate depressed from demented clients. Wells (1979) emphasized the importance of getting a careful history of the disorder. (Depressed clients usually develop the symptoms of depression before the onset of cognitive decline.) In addition, cognitive impairments often fluctuate with changes in level of depression. Reports that demented persons are invariably unaware of their cognitive deficits, thus differentiating them from depressed persons, appear to be untrue: many with progressive dementia are aware of their impairments and the advancement of their deficits.

One may find depressed clients who undergo cognitive testing with an instrument such as the Mini-Mental State Exam and other cognitive tests will actually perform better with time; that is, the depressed person may remember one or none of three items after 3 minutes but will remember all three if asked again after 15 minutes. Such an improvement in memory would be very unlikely in someone with a progressive dementing illness and is highly suggestive of a psychopathologic disorder.

The rates of depression reported in dementing individuals vary considerably and probably reflect differences in the definition of both depression and dementia. Prevalence among studies were 0%–40% for depression among demented clients.

In one study, Merriam and associates (1988) obtained behavioral data from a structured interview of caregivers who knew clients well, rather than directly from client-interviewer interaction. They found fully 86% of their sample of 175 cognitively impaired subjects met full DSM-III criteria for major depressive episode. With that in

mind, they question the appropriateness of using DSM-III criteria in that population and noted the common clinical dilemma in which **many of the symptoms of depression are present in demented individuals who are clearly not depressed.** They found **the overwhelming majority of their "depressed" clients were consistently able to be cheered or distracted, even when most despondent;** thus diagnostic criteria that ignore the capacity for depressed demented clients to be distracted or cheered may yield false-positive diagnoses of depression.

Depression in an elderly person has been suggested to be a warning of an underlying early dementing illness (Reding, Haycox & Blass, 1985). **Of 225 persons referred to a dementia clinic over a 3-year period, 57% of those initially believed to be depressed and nondemented went on to develop frank dementia. Many initially had some sign, often subtle, of neurological disease.** For example, depressed elderly persons were found to be at high risk of developing dementia if any of the following were present: cerebrovascular, extrapyramidal, or spinocerebellar disease; a modified Hachinski ischemic score of 4 or greater; a Mental Status Questionnaire score under 8; or confusion on low doses of tricyclic antidepressants.

Many persons suffer from both depression and structurally based intellectual impairment. Vigorous therapeutic intervention may benefit the affective state, even when there is no rebound in neuropsychological deficits, with resultant improvement in the functional status of the client. Ideally, the uncertain clinician will initially consider the depressed, dementing individuals to be suffering from pseudodementia, where there is hope for recovery, and will begin antidepressant therapy.

It is important to **guard against fatalistically assuming the cognitively impaired depressed individual is irretrievably demented and as such withhold treatment. Therapeutic interventions should be based on the presence of responsive target symptoms and, although diagnosis is important, it may not be essential for initiating treatment measures.** Distinguishing between a psychopathologic and neurologic disorder may not be necessary as long as one establishes that the course is nonprogressive and has completed a work-up to rule out other treatable etiologies.

Psychotherapy

Considerable evidence indicates antidepressant medication is more effective when used in combination with some type of psychotherapy (Goff & Jenike, 1986). In 1968, only 2% of clients attending outpatient psychiatric facilities or treated by psychiatrists in private practice were over age 65 (Steuer, 1982), and that situation has changed only slightly since.

That underuse of services may reflect a cultural bias whereby professionals might believe resources should go to younger clients who have more years of life ahead of them and who are more economically productive. Some may view the elderly as inflexible or consider decline inevitable, whereas others may believe special knowledge is required to help the aged. Countertransference issues may surface: **some elderly clients view therapists as they would their children, so unresolved conflicts with the therapist's own parents may interfere with objective treatment. Mental-health-system factors—reimbursement inequities, lack of cooperation among community mental health centers and physicians, discrepant perceptions of the help that is needed, and the lack of referrals from other physicians who have contact with older clients in need of mental health services—may be the most important reasons why few older adults are seen by mental health professionals.**

Despite a bewildering array of psychotherapeutic approaches available for use with the elderly, **no studies adequately address psychotherapy outcome in these age groups.** Despite a lack of hard evidence, **Butler (1975) hypothesized that four common principles underlie the process of all psychotherapeutic approaches in the elderly: fostering a sense of control, self-efficacy, and hope; establishing a relationship with the caregiver; providing or elucidating a sense of meaning; and establishing constructive contingencies in the environment.** Butler also cited themes common in old age, such as physical dysfunction, dependence, concerns with time, and stereotyping by the young. Concerns about the meaningfulness of life and feelings of uselessness are also common, so therapists may help the aging client resolve existential crises through reminiscence and self-evaluation.

Busse and Pfeiffer (1977) recommended active mapping and clarifying of the client's problems by the therapist and the establishment of limited goals such as symptom relief, support for adaptation to changing life circumstances, acceptance of greater dependency as a normal aspect of the aging process, and renewed or continued involvement in useful activity. They also encouraged social conversation during part of each session to enhance the client's thoughts of being part of a meaningful relationship. Blume and Tross (1980) pointed out the importance of regularly scheduled sessions as a source of constancy in what may be a life filled with change.

As a means of increasing a client's sense of self-worth, Burnside (1978) recommended the therapist consider touching geriatric clients to express caring and gain their attention. Linden (1957) stressed the importance of optimism in the therapist and emphasized that the therapist's personality is a main consideration in psychotherapy outcome. A number of ag ncies and groups are particularly useful in the management of elderly clients and their families in specific circumstances. Support groups and programs involving visits to housebound clients have been shown to reduce psychological symptoms and social isolation. Programs that enlist elderly persons as teachers, advisors, and consultants benefit both the helpers and those helped. Foster grandparent programs place older adults in positions to help children in various school or hospital settings. Pet therapy—which may afford companionship, demand responsibility in terms of caring for the animals, and provide physical contact—is reported to help relieve feelings of isolation, loneliness, and uselessness.

Psychotic Depression

An estimated 30%–40% of the admissions to acute-care psychiatric hospitals in the United States are of depressed individuals, and those who are delusionally depressed account for at least 5% of the admissions to such hospitals (Spiker, et al., 1985). Those who are psychotically depressed have much longer hospital stays,

with an average of about 50–60 days (Brown, et al., 1982; Frances, et al., 1981). Delusionally depressed clients were unable to perform their usual daily activities for an average of 47.6 weeks before hospital admission (Spiker, et al., 1985). They also had a higher risk of suicide than the nonpsychotically depressed. Thus, psychotic depression has major social and economic implications for clients, their families, and society in general.

Treatment of delusionally depressed clients is a subject of some controversy. Some who are delusionally depressed improve with antipsychotic medication alone and others with a tricyclic alone. Most studies, however, show response rates of less than 50%, and some have been criticized because not enough medication was given over a sufficient length of time. Whether the efficacy of combining an antidepressant and an antipsychotic to treat those with a delusional depression holds only for those two classes of drugs remains to be determined.

Grief

Normal grief is *not* generally associated with a morbid sense of worthlessness or prolonged impairment, as is common in clinical depression. Uncomplicated mourning may last up to a year, although vestiges of grief may continue longer, often triggered by anniversaries, losses, or other reminders of the loved one. The loss is never fully resolved, but the stresses of bereavement may strengthen persons and families, refocusing their energies and deepening other attachments.

Sometimes grief can reach pathologic depths and can merge with depression to necessitate treatment (Clayton, 1974). Health care providers should be watchful and supportive in times of bereavement without overemphasizing the possibility of adverse effects—listening, reassuring, reaffirming, referring survivors when appropriate to specific self-help groups, and sometimes sharing directly in the grief. Special vigilance is required for unusually vulnerable subgroups, such as those with mental disorders, alcoholism, or limited social support. Men appear to be more vulnerable, for unknown reasons.

Pharmacologic Treatments

HETEROCYCLIC AGENTS:

Since the introduction of imipramine (Tofranil), heterocyclics have been the mainstay of pharmacologic treatment for depression. Because such agents are considered by most to be equally effective, the selection of a specific drug should be based on side effects.

Tertiary amines such as amitriptyline (Elavil) and imipramine (Tofranil) are much more likely to cause orthostatic hypotension than secondary amines, which include desipramine (Norpramin), protriptyline (Vivactil), and nortriptyline (Aventyl) (Jenike, 1989; Salzman, 1982). Doxepin (Sinequan), a tertiary amine, is an exception, and it appears to be safe in the elderly in terms of orthostatic changes (Neshkes, et al., 1985). In general, tertiary amines also tend to produce more sedation (Richelson, 1982). Anticholinergic and noradrenergic side effects are also particularly troublesome. Anticholinergic symptoms may be prominent both centrally, in the form of delirium, confusion, and cognitive impairment, as well as peripherally, including tachycardia, urinary retention, constipation, blurred vision, and dry mouth. If desipramine is assigned an anticholinergic potency of 1, amitriptyline would be scored an 8. The other tricyclics lie somewhere in between, with a relative potency of about 2.

Amitriptyline is generally regarded as the tricyclic most likely to cause clinically hazardous tachycardia (Cassem, 1982), and the combination of pronounced anticholinergic activity and danger of orthostatic hypotension makes amitriptyline the least desirable of all the available tricyclics (Jenike, 1989). Because of the well-documented abnormalities in the cholinergic system in dementing individuals and the effects of anticholinergic drugs on memory even in normal subjects, any anticholinergic medication given to a dementing individual will worsen cognitive functioning regardless of any improvement in affective state.

If a client has shown a prior positive response to a particular drug, it may be

best to begin treatment with that drug. Low doses of secondary amine tricyclics with relatively low anticholinergic activity should be the recommended drugs of first choice. If a depressed person is not sleeping well, trazodone (Desyrel), nortriptyline, maprotiline (Ludiomil), doxepin, or trimipramine (Surmontil) given at bedtime may improve insomnia during the early stages of treatment. For hypersomnic or lethargic clients, daytime doses of desipramine, protriptyline (Vivactil), or fluoxetine (Prozac) may help activate the person (Jenike, 1989). However, those so-called "activating agents" may in fact sedate some clients, who should therefore take their medication around bedtime. Amoxapine (Asendin) has been reported to cause acute dystonia, parkinsonism, and akathisia (Barton, 1982), as well as tardive dyskinesia (Lapierre & Anderson, 1983). Because the elderly are particularly prone to develop tardive dyskinesia, and because the movements associated with it are much less likely to be reversed in older individuals (Jenike, 1983), amoxapine should be avoided in that population.

Trazodone is similar in efficacy to the standard tricyclics but has a very low incidence of anticholinergic side effects except for complaints of dry mouth among some. As long as they are not overly sedated during the day, the elderly seem to tolerate trazodone very well. Other common side effects of trazodone include indigestion, nausea, and headaches. Priapism with trazodone is a rare problem, but men should be cautioned to discontinue the drug if prolonged or painful erections occur. The incidence in elderly men is not known, but it appears to be lower than that in the general population. The antidepressant fluoxetine (Prozac) appears to be relatively free of major side effects and may be useful for the elderly.

If antidepressants are not helpful after a reasonable trial, a blood level determination, when available, will assist the clinician in determining the next step. At the same dosage, antidepressant blood levels can vary as much as 30 times between individuals. Even though many elderly will respond to very low dosages of an antidepressant, others will require the same as younger patients. If clients fail to respond, and side effects are not a problem, the dosage must be aggressively increased. However, some clinicians, fearing high dosages of antidepressants in the elderly, chronically underdose their geriatric clients.

MONOAMINE OXIDASE INHIBITORS:

Among somatic treatments available for the depressed elderly, monoamine oxidase (MAO) inhibitors are the least used. The correlation between MAO activity and age is positive (Jenike, 1989), but MAOIs can be used safely for treating the elderly if certain precautions are taken (Quitkin, et al., 1984). Many who do not respond to tricyclics or some of the newer antidepressants will improve with MAOIs. Also, MAOIs may be especially effective in treating dementia-related depression (Ashford & Ford, 1979; Jenike, 1985).

Because MAOIs have essentially no anticholinergic effects, they are useful for those with dementing illnesses or those elderly who develop urinary retention with low doses of desipramine. Some women taking MAOIs are unable to achieve orgasm, however. Serious hepatic toxicity is rare with those MAOIs currently available. The side effects of MAOIs that cause the most problems for the elderly are hypotension and insomnia.

Orthostatic hypotension is a dangerous side effect for geriatric patients, because they tolerate falls poorly. Orthostatic changes should be monitored, at least throughout the first month of treatment. Complaints of mild light-headedness and unsteadiness secondary to the postural hypotension may be heard during the first few weeks, but small amounts of coffee or tea can produce a rise in blood pressure sufficient to control the problem. If symptoms are severe, the MAOI should be discontinued. Rarely, a disinhibition syndrome characterized by talkativeness, extroversion, antisocial behavior, and hypomania occurs that is often exacerbated by alcohol or benzodiazepines (Walker, Davidson & Zung, 1984). It can be treated with lithium carbonate or by lowering or stopping the medication. Neuropathy secondary to vitamin B_6 deficiency occurs rarely and can be treated with pyridoxine (Aminoxin). Occasional generalized edema occurs, but it usually subsides within a week without specialized intervention. Weight gain, often associated with carbohydrate craving, can be significant during the first few months of treatment.

The most important adverse effect associated with MAOIs is the uncommon but frightening occurrence of a hypertensive crisis caused by a toxic interaction with certain drugs or tyramine-containing foods. Aged cheese in particular has been involved in virtually all fatal reactions (Walker, Davidson & Zung, 1984). The elderly person who has fragile atherosclerotic blood vessels could easily suffer a stroke during such a hypertensive episode. Severe hypertensive reactions can be treated with the alpha-adrenergic blocker, phentolamine (Regitine), diazoxide (Hyperstat), sodium nitroprusside (Nitropress), chlorpromazine (Thorazine), or labetalol (Trandate). It is essential that all clients on MAOIs are informed of dietary and drug precautions (Jenike, 1989). Elderly clients comply well and rarely complain about such restrictions.

A poorly understood yet potentially fatal toxic interaction can occur between MAOIs and meperidine hydrochloride (Demerol). Clinically, patients appear agitated, disoriented, cyanotic, hyperthermic, hypertensive, and tachycardic. Chlorpromazine is an effective treatment. Novocain and xylocaine, which are used during minor surgery or dental work, are safe if they do not contain sympathomimetic vasoconstrictors. If possible, MAOIs should be discontinued 2 weeks prior to elective surgery, because inhalation of anesthesia can cause hypotensive reactions in patients on MAOIs. Succinylcholine (Anectine) has led to prolonged apnea in patients receiving electroconvulsive therapy and concomitant phenelzine therapy.

Some of the new drugs on the market, such as buspirone and fluoxetine, have been associated with toxic reactions when used concomitantly with MAOIs. At the Massachusetts General Hospital, we have for a number of years routinely used MAOIs as maintenance therapy for elderly persons who have received electroconvulsive therapy for severe depressive disorders. To our knowledge, no one developed a hypertensive episode; the overwhelming majority tolerate those agents very well. MAOIs have no known long-term adverse effects such as tardive dyskinesia, which occurs with chronic use of neuroleptics.

Clinicians frequently find the positive antidepressant effects of MAOIs begin to decrease over a few weeks. Full antidepressant effect can usually be regained by increasing the dosage or, if the client is already at the maximum dose, by stopping the medication completely for 1 or 2 weeks and restarting it.

PSYCHOSTIMULANTS:

Psychostimulants, such as methylphenidate (Ritalin) or dextroamphetamine (Dexedrine), were used as antidepressants until the advent of the tricyclics. Recent studies advocating their use in medically ill depressed patients, as adjuvants to morphine in the treatment of postoperative pain, and for adjustment reactions in patients recovering from chronic illnesses or surgical procedures, have rekindled interest. Dextroamphetamine is roughly twice as potent as methylphenidate.

At our hospital, stimulants are frequently used to treat the medically ill or postoperative elderly who are apathetic, withdrawn, or depressed. We also frequently find that **stimulants are helpful for those with abulia (lack of initiative) secondary to frontal lobe disease or in demented persons with coexistent retarded-depressive features.**

Hackett (1978) has described the usefulness of psychostimulants in diagnosing and effectively treating medically ill, apathetic, weakened patients in whom depression might be easily masked by their concomitant illness. Duration of treatment is usually empirical and individualized to the clinical situation (Kaufmann, et al., 1984).

Potentiation of Antidepressant Drugs by Lithium or Thyroid Hormone

Lithium may be a useful adjuvant in tricyclic antidepressant-resistant unipolar depression, and L-triiodothyronine (T_3, Thyrolar) has also been reported to potentiate the effect of the tricyclics. Despite the well-established efficacy of tricyclic antidepressant agents, controlled studies indicate the rate of nonresponse or partial response is in the range of 20%–35%, and only scant data are available on the length of required treatment for the depressed person who has been successfully treated with medication. There may be a gap of several weeks or even months between the initial control of symptoms and the end of the episode. During that time, relapse may occur if medication is discontinued. Results from a

collaborative project of the National Institute of Mental Health (Prien & Kupfer, 1986) suggest persons should be free of significant symptoms for 16 to 20 weeks before treatment is discontinued. **Antidepressant medication should be continued for 4 or 5 months after the resolution of acute depressive symptoms, and clinicians should have frequent contact with the individual during the first 2 months after discontinuing antidepressant medication because of the chance of relapse.**

INDIVIDUALS WITH CARDIAC CONDITIONS:

Many cases of moderately severe depression probably go untreated because of unwarranted fears about the cardiac side effects of antidepressants. **There are four main side effects of particular concern when prescribing antidepressants for cardiac patients: orthostatic hypotension, anticholinergic effects, decreased cardiac contractility, and cardiac conduction effects.**

Tertiary amine tricyclics, including amitriptyline and imipramine but excluding doxepin, tend to cause more severe hypotensive effects than secondary amines such as nortriptyline and desipramine (Neshkes, et al., 1985). **Newer agents such as amoxapine, maprotiline, and trazodone appear to offer no advantage in avoiding orthostatic hypotension** (Cassem, 1982).

The mean orthostatic drop with phenelzine over time has been found to increase in a generally linear fashion and **appeared to be consistent across age groups** (Kronig, et al., 1983). **However, the consequences of a fall in blood pressure in an old person are much more likely to be serious. Lithium therapy is not associated with orthostatic hypotension.**

Cardiac patients who have ischemic disease are least able to tolerate an increase in heart rate. In general, tertiary amines are more potent anticholinergic agents than secondary amines, with amitriptyline significantly exceeding all other tricyclics (Cassem, 1982). Amoxapine and maprotiline offer little improvement over earlier tricyclics in terms of anticholinergic properties. **Trazodone, however, has no anticholinergic effects and may be useful in patients at risk from tachycardia.** The MAOIs also have virtually no anticholinergic side effects (Jenike, 1984). No

regular changes in cardiac rhythm have been associated with the MAOIs, even in cases of overdose. **Lithium also has no anticholinergic effects and does not produce tachycardia** (Cassem, 1982).

Most early studies to detect a link between antidepressants and decreased contractility employed indirect measurements of cardiac function, such as systolic time intervals, that could have reflected slowing of H-V conduction commonly produced by tricyclics (Cassem, 1982). Veith and associates (1982) measured ejection fractions in vivo before and during maximum exercise in depressed persons with heart disease who were taking therapeutic doses of imipramine and doxepin. They found **no adverse effects on left ventricular function.** Glassman and colleagues (1983) also studied a group of depressed persons with clinically significant pre-existing left ventricular dysfunction by means of radionuclide angiography. **Therapeutic levels of imipramine did not further impair left ventricular performance, and the ejection fraction was unchanged during treatment. Also, no evidence links the newer nontricyclic agents, lithium, or the MAOIs with cardiac contractility.**

Tricyclics slow conduction (Cassem, 1982; Moss, 1986). At one time no relationship was believed to exist between the initial PR and QRS intervals and drug-related change after starting imipramine; however, Roose and colleagues (1987) reported a possible **increased risk of cardiac changes with imipramine, so patients should be monitored carefully. Prolongation of the QT interval is rarely associated with an increased likelihood of tricyclic-induced malignant ventricular arrhythmias** (Moss, 1986). **Heterocyclic agents should be used with extreme caution, if at all, in those with predrug corrected QT intervals greater than 0.44. Clinical problems associated with slowed conduction are rare** (Giardina, et al., 1979). Of those who overdose on tricyclics, only 6%–20% develop significant clinical problems with conduction abnormalities (Callahan, 1979). Increases in PR and QRS intervals are directly related to tricyclic plasma levels (Giardina, et al., 1979).

The risk of worsening cardiac arrhythmias with antidepressant therapy has been overemphasized in the past, since imipramine (Raskind, et al., 1982), **nortriptyline** (Giardina, Bigger & Johnson, 1981), **and probably the other tricyclic**

antidepressants are actually effective antiarrhythmic agents, similar in action to quinidine (Cardioquin) and procainamide (Pronestyl) (Giardina, et al., 1979). In fact, patients on the last two drugs should be followed carefully; their antiarrhythmic medication may need to be reduced when a tricyclic antidepressant is added. Case reports (Cassem, 1982; Zavodnick, 1981) have linked both amoxapine and maprotiline to arrhythmias. Trazodone is generally free of clinical conduction problems in healthy individuals, but it has been associated with arrhythmias in patients with preexisting cardiac illness. No consistent changes in cardiac rhythm have been associated with the MAOIs, even in cases of overdosage (Cassem, 1982). Toxic cardiac effects are uncommon with lithium, but reversible sinus node abnormalities and other conduction disturbances have been reported. Cassem (1982) recommends continually monitoring patients with preexisting cardiac conduction abnormalities during the initiation of lithium therapy.

FOLLOW-UP:

Individuals with heart disease can generally be managed on antidepressant medication. All elderly patients with heart disease, however, should have occasional ECGs. Inquiry about cardiac symptoms should be made at each visit. Patients should be examined for rales and the presence of changing heart sounds.

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Questions Based on this Lesson

33. Which of the following statements is correct?
    A. Over age 65, women have three times as great an incidence of depression as men
    B. The estimated incidence of depression in populations over 65 is 28%
    C. White men over 65 have a suicide rate four times the national average and twice as high as women in the same age group
    D. Untreated major depression is associated with a markedly reduced risk for cardiac disease

34. In elderly clients with major depression, which of the following statements is *not* correct?
    A. Depression usually precedes evidence of cognitive decline
    B. Cognitive impairments often fluctuate with mood changes
    C. Adequate treatment usually leads to improved cognitive performance
    D. Depression is never an early warning sign of impending dementia

35. Tertiary amine antidepressants such as amitriptyline and imipramine:
    A. Are drugs of choice in the elderly
    B. Are more likely to cause orthostatic hypotension and sedation than secondary amines such as desipramine and nortriptyline
    C. Possess less in the way of anticholinergic side effects than drugs like desipramine, and hence are less likely to induce delirium and cognitive impairment in the elderly
    D. Are singularly free of cardiovascular side effects such as tachycardia

36. Among the elderly:
    A. Excessive crying may be a sign of neurological disease
    B. Depression never appears as anxiety or somatic concerns
    C. Memory difficulty is always a sign of organic brain disease and never accompanies depression
    D. Suicidal thinking by itself always justifies a DSM-III-R diagnosis of major affective disorder

Directions in Mental Health Counseling

VOLUME 2 • LESSON 10

Therapeutic Approaches Toward Clients with a History of Incest in Childhood

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VOL. 2, NO. 10

October 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING (ISSN # 1062-0788, USPS # 008-015) is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

Childhood sexual abuse, including incest, has received much attention in recent years. It's estimated that 10% of men and up to 30% of women report childhood experiences of sexual activities with adults or older children. Emphasis has been placed on early detection, treatment, and prevention; in every state, laws require professionals to report suspected cases of intrafamilial sexual abuse. Victims do not necessarily develop psychiatric illnesses later on as adults, but various disorders—such as borderline states, post-traumatic stress disorder, and multiple personality disorder—are seen, and the dynamic of early life sexual abuse or incest may well be a contributing factor. Adults with histories of incest often manifest mistrust of the motivations of themselves and others. They frequently test interpersonal boundaries; stunting in the development of social skills may set the stage for seductive behavior or intimidation as coping strategies.

Different models of treatment—the psychoanalytic, the medical, the feminist, and a model derived from the child protection movement—differ substantially with regard to theoretical issues but share many management guidelines. For example, clinicians from each perspective would usually agree that specific psychiatric disorders when present should be appropriately treated, maladaptive character traits modified, rehabilitation efforts facilitated, and negative sequelae prevented. While most would agree that patients should have the opportunity to discuss the incestuous experiences with a therapist knowledgeable about psychological distress associated with incest, opinions differ on the necessity for the patient to address incestuous experiences directly as part of therapy. In working with such patients, the therapist must be particularly careful to maintain clear boundaries at all times; in extreme cases, failure to do so may lead to circumstances conducive to sexual exploitation by the therapist.

Introduction

In choosing therapeutic approaches for clients with histories of incest in childhood, mental illness specialists immediately find themselves in a quandary. On the one hand, the past decade has been characterized by heavy emphasis on the recognition and reporting of incest, sexual abuse, and other forms of child abuse, with extensive publicity on these subjects. In addition, some states now require psychologists, physicians, and other health professionals to demonstrate participation in approved courses on abuse as part of applications for renewal of professional licenses. On the other hand, **the major therapeutic approaches that have been advocated for such clients differ significantly in their origins, assumptions, goals, methods, and criteria for efficacy.**

Crucial distinctions concern disputes over not only how but also what to treat in those with histories of incest. Should the focus be on the meaning of the recollection of incest, on the oppression of the victim by the perpetrator, on the dysfunctional family system that may underlie the incestuous behavior, or on specific psychiatric disorders with which incest may be associated? Therapeutic approaches stem from at least four distinct perspectives—psychoanalysis, the women's movement, the child protection movement, and descriptive psychiatry (Finkelhor, 1984)—each of which offers different answers to such questions.

The clinician seeking guidance in this area must turn to sources beyond the standard texts. Neither the term incest nor the phrase sexual abuse is included in the index of DSM-III-R (American Psychiatric Association, 1987) or of the four-volume, 2183-page *Treatments of Psychiatric Disorders*, published in 1989 by the American Psychiatric Association. The index of *The American Psychiatric Press Textbook of Psychiatry* (Talbott, Hales & Yudofsky, 1988) has a brief listing for incest but no listing for sexual abuse. Only brief chapters on rape, spouse abuse, and incest (Sadock, 1989) and on physical and sexual abuse of children (Green, 1989) are contained in the fifth edition of the *Comprehensive Textbook of Psychiatry*.

In contrast to the relative paucity of discussion of the topic in the standard diagnostic manual and the major texts, a deluge of papers have appeared in professional journals during the past several years. **Major trends in this literature include an increased emphasis on research methodology in studies of the association between incest and mental disorder, a consensus that incest and sexual abuse are strong risk factors for mental disorder and psychological distress, a relative lack of emphasis on methodology in treatment studies, and the aforementioned sharp differences of opinion regarding treatment indications, methods, and goals. Most studies have focused on girls or women with histories of incest, whereas relatively little systematic information is available on possible associations between histories of incest and mental disorders in boys or men and psychopathologic aspects of intragenerational or homosexual incest.**

Despite the lack of consensus on treatment, clinicians who work with adults regularly encounter clients who give histories of incest or sexual abuse in their childhood. Those who work with children and adolescents encounter cases on an almost-daily basis in which there have been recent allegations or legal findings of incest or sexual abuse.

Definition

The term incest has been used in the professional literature to refer to a wide range of sexual activities ranging from voyeurism to touching to kissing to fellatio to intercourse between persons of varying degrees of biological, legal, or social relatedness. Legal definitions in incest statutes tend to be more specific than psychopathology definitions and vary considerably from state to state (Bienen, 1981). In addition, the term has often been used synonymously with other phrases such as sexual abuse, sexual molestation, and rape in the professional literature on childhood sexual experiences. Many cases of sexual abuse of children are intrafamilial and do involve incest, but the comparison of incestuous abuse of children to rape of

adult victims is limited in that incest often begins insidiously and recurs frequently over long periods of time, whereas rape often involves a single traumatic episode of sudden onset.

Epidemiology

Throughout the first half of this century, estimates of the frequency of incest based on criminal convictions for the offense indicate an occurrence rate of about one case per million population per year (Weinberg, 1955). More-recent estimates by the National Center on Child Abuse and Neglect, based on reports to child protection systems, indicate an incidence of allegations of sexual abuse of about 100,000 cases per year in the United States (U.S. Department of Health and Human Services, 1981) or about 5 cases per 10,000 population. Eighty percent of reported victims of sexual abuse are women and girls; 70% of reported perpetrators are men and are parents of the victim, although only a little over half (56%) are natural parents of the victim. The most frequently reported form of sexual abuse is intercourse. Thus, most reported cases of sexual abuse are intrafamilial, involve fathers and daughters, and can be classified as incest. The demographic profile of families in which sexual abuse is reported more closely resembles that of the average American family rather than the profile of families in which other forms of abuse are reported (Russell & Trainor, 1984).

Estimates of prevalence of incest (total number of cases at a given time or over a specified period of time) usually stem from surveys of adults who report sexual experiences in childhood and from extrapolations of data on incidence. Results from such surveys indicate up to 10% of men and up to 30% of women report childhood experiences of sexual activities with adults or older children (Finkelhor, 1979; Russell, 1983; Sedney & Brooks, 1984).

All estimates of incidence and prevalence of incest are subject to severe methodological limitations, including possible under- or over-reporting, variations

in definitions of activities reported, and difficulties in verification of reports. In addition, the developmental context of touching between children and parents remains an underexplored area of investigation. A questionnaire survey of a nonclinical sample of mostly Caucasian, upper-middle-class parents by Rosenfeld and colleagues (1986) found over 30% of responding parents of girls under the age of 10 years gave an answer other than "never" to questions regarding the girls' touching of their father's genitals and that 45% of the parents of 8- to 10-year-old boys answered other than "never" to questions regarding the boys' touching of their mothers' breasts or genitals.

Association with Mental Disorder

Many studies throughout this century have implicated incest and sexual abuse in childhood and adolescence as a risk factor for mental disorder. **Such studies have been based on retrospective recall of adult clients regarding sexual experiences in childhood, on direct examinations of children and adolescents referred to mental health clinics because of sexual abuse, and, more rarely, on follow-ups of such children and adolescents. Mental disorders reported in association with incest and sexual abuse have ranged from the acute (adjustment reactions, psychoses) to the chronic (conduct disorders, schizophrenia, borderline and multiple personality disorder) to those with delayed onset (hysteria as described by Freud, post-traumatic stress disorder).**

Recent reviews of the literature have pointed to **multiple limitations that have plagued study designs** in this area of research (Abright, 1986; Browne & Finkelhor, 1986; Conte, 1985). These have included lack of definition, specificity, and corroboration of incest or sexual abuse; problems in sample sizes and selection; lack of assessments of mental health status of victims prior to the abuse; and changing criteria for mental illness diagnoses. In addition, there is a tendency to assume a causal relationship between incest or sexual abuse and mental disorder. Most studies have not included comparison groups or adequate controls for other concurrent factors (such as

psychosocial adversity, parental mental illness, parental discord, and loss of parent), which many victims of abuse have experienced and which are also known to be related to mental disorder.

Generally, such reviews conclude some but not all victims of sexual abuse in childhood and adolescence develop mental disorders at some point in their lives. In addition, the disorders for which such individuals are at risk cover a wide variety of psychopathologic entities, and evidence is insufficient to establish an invariable link between sexual abuse and any specific disorder or syndrome.

The above discussion refers mainly to rates of mental illness diagnosed in individuals who have been sexually abused in childhood. Other studies have used standardized measures of psychological functioning apart from diagnosis.

In a review of studies of female victims between 1956 and 1985, Browne and Finkelhor (1986) found the **initial effects (i.e., within two years of the abuse) that were noted included "fear, anxiety, depression, hostility, and inappropriate sexual behavior." Long-term effects noted in adult women who were abused as children included "depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency towards revictimization, and substance abuse," as well as "difficulty in trusting others." Findings with regard to sexual dysfunction and promiscuity were not consistent.**

In summary, Browne and Finkelhor found **"...within the immediate aftermath (i.e., within 2 years) of sexual abuse, from one-fifth to two-fifths of abused children seen by clinicians manifest some noticeable disturbance..." and "...when studied as adults, victims as a group demonstrate more impairment than their nonvictimized counterparts (about twice as much), but less than one-fifth evidence serious psychopathology."**

With regard to factors that contribute to the likelihood of mental disturbance in victims of childhood sexual abuse, Browne and Finkelhor concluded **longer-lasting**

experiences, more than one incident of abuse, abuse by a father or a stepfather, use of force, abuse by male perpetrators and by adult perpetrators, and lack of family support for the victim or removal of the victim from the home all may be associated with worse psychological outcomes. The relationship with negative psychological outcomes of age of onset, type of sex act (i.e., intercourse or other abuse), impact of revealing the abuse or keeping it a secret, or abuse by relatives other than fathers or stepfathers have shown more ambiguity.

Evaluation

The conclusion that incest is a significant risk factor for mental disorder implies **comprehensive evaluation is warranted for all children and adults with histories of incest and tactful and developmentally appropriate inquiry regarding a possible history of incest or other forms of sexual abuse is warranted in clients in general. Such investigation is especially important for those with conditions such as multiple personality disorder** (Coons, 1986), **borderline personality disorder** (Shearer, et al., 1990; Westen, et al., 1990), **or post-traumatic stress disorder** (McLeer, et al., 1988), from whom such histories have frequently been elicited. **Histories of childhood incest are also common in clients who report sexual involvement with their therapists** (Kluft, 1989).

Evaluations should include comprehensive developmental histories; careful inquiries regarding mental status prior to the experiences of incest, other risk factors for mental disorder, and areas of strength as well as weakness in the client's character, family, and social circumstances; mental status examination; and response to previous interventions. Hypnosis has been recommended as part of the evaluation of some clients with dissociative disorders (Spiegel, 1989). **Examinations of children should be supplemented with interviews of parents and other family members as well as information from schools and other sources.** Conjoint family interviews with the child, parents or caretakers, and other relatives may be useful, but the child should

also be given ample opportunity to speak in private with the evaluating therapist or counselor.

In children, in addition to mental status evaluation, attention must be directed toward assessing the allegation of incest, the current safety of the child, the need for protection from further abuse, and the status of the case in the child protection system or the criminal justice system. A full medical evaluation should be performed to detect any associated physical injuries or sexually transmitted diseases. Laws in all states require ***mandatory reporting of suspected cases*** of intrafamilial sexual abuse by physicians, teachers, and others in professional relationships with children and families and render such professionals liable to charges of criminal misdemeanor for failure to report.

Validity of Reports of Incest

Controversies about the validity of medical and forensic reports of incest date back at least as far as the mid-nineteenth century (Masson, 1984), and theories about the role of real and imagined sexual experiences in childhood were central to the early development of psychoanalysis. Contemporary professional literature on incest contains critical allusions to Freud's revision of his seduction theory to emphasize the importance of fantasy in the genesis of psychic conflict and of recollections by adult clients of early childhood sexual experiences. Several generations of psychoanalysts have been denounced for their reluctance to accept such recollections as facts. What is often overlooked is that Freud himself did not entirely abandon the belief that sexual activities between adults and children can, and sometimes do, take place and can have harmful psychological consequences (Gay, 1988).

In light of statistics available in the past 30 years that indicate a much higher prevalence of incest and sexual abuse than were suggested by previous statistics,

current psychoanalytic writers seem more inclined to accept the view that at least some clients have suffered actual experiences of childhood incest and those experiences have had distorting influences on their development (Stone, 1989). Shengold (1989) summarizes this position: "It does make a difference whether something actually happened [but] this does not deny the pathogenic power of fantasy."

Clinicians working from the feminist perspective tend to place more automatic credence in adults' recollections of childhood abuse. Thus, Courtois (1988) writes, "In incest therapy, the abuse not only is given credence but becomes the main, although not the sole, focus of the treatment. The client is believed."

Questions regarding the validity of allegations of sexual abuse of children have generated controversies similar in intensity to those surrounding the validity of adults' retrospective recall of childhood sexual experiences. Discussion of those issues is beyond the scope of the present lesson; for further information the reader is referred to recent writings on child abuse (Krener, 1987) and custody disputes (Herman, 1991) in which such allegations may arise as well as to the guidelines for evaluation of possible sexual abuse issued by the American Academy of Child and Adolescent Psychiatry (1988).

Indications for Treatment

Proponents of the major approaches to treatment of clients with histories of incest differ significantly with respect to indications for treatment. For example, Stone (1989) expresses a point of view held by many clinicians: "Before discussing approaches to some of these specific symptoms and syndromes, I think it is worth emphasizing that the experience of incest inevitably distorts one's perceptions and one's expectations of self and the world of adults so grossly as to render psychotherapy (in all but the mildest instances, in the strongest persons) mandatory."

In contrast, Goodwin (1987), referring to the "wide spectrum of responses" in victims of incest, points out the reported high prevalence of "prolonged secret sexual

contact" between girls and "father figures" suggests it is "a condition that now occurs more frequently than does tonsillectomy." She challenges "assumptions of automatic and profound harm" and asserts, "...if sexual abuse of children is as common as it now seems, there must exist patterns of effective coping as well as pathology."

Courtois (1988) takes the argument further, stating the philosophy of treatment of incest victims is "to treat the incest directly" and advocating a treatment approach in which "the medical model of psychopathology is replaced with the traumatic stress and feminist models supplemented by the family systems approach to conceptualize the abuse and its after effects."

Despite such controversies, the presence of clear-cut signs and symptoms of mental illness remains the strongest indicator of a need for treatment in children and adults.

"Incest Syndrome"

Although nosological validity and reliability have not been established for a specific "incest syndrome," awareness of themes frequently manifested by children and adults with histories of incest may be helpful in evaluation and treatment. **Such themes in children include guilt over the incestuous activities, disclosure, and consequent disruption of the family; grief and possibly depression over separation from the incestuous parent or other relative; denial of the incestuous events alternating with disclosure; resentment of the nonincestuous parent or other relatives or caretakers who may be viewed as having permitted the incest to occur; and masking of other problems (intrapsychic, interpersonal, or academic).**

Residues of such themes may also be prominent in adults with histories of incest. Mistrust of the motivations of oneself and others, frequent testing of interpersonal boundaries, severe impairment of self-esteem, and a stunting of the development of social skills in favor of the use of seductive behavior or intimidation may be present in both children and adults with histories of incest.

Goals of Treatment

The goal of treatment in cases of incest varies with the model employed. The goal in the **psychoanalytic model** is mastery of internal conflict through analysis of transference and resistance; in the **medical model** it is the relief of signs and symptoms of disorder. The **feminist model** works toward the transformation of feelings of rage and helplessness as a victim into constructive self-assertion. **The model derived from the child protection movement** seeks the repair of a dysfunctional family system.

Although theoretical differences are sharp, in practice **most clinicians from each perspective would probably agree general guidelines for goals should include treatment of specific disorders when present, relief of symptoms, alteration of maladaptive character traits, reduction of interference in developmental steps, facilitation of other attempts at remediation or rehabilitation, and prevention of negative sequelae.**

Methods

Treatment methods described have included short- and long-term individual, group, and family therapy and environmental changes. Among the issues in each method are the extent to which exploration of recollections of the incestuous experiences is necessary to achieve therapeutic results, impediments to the therapeutic alliance, gender differences between client and therapist, boundaries in the treatment, and attitudes towards disclosure.

The comments below will focus mainly on individual therapy with adult clients, but they are also generally applicable to therapy with children and adolescents. Special considerations regarding a possible need for environmental changes and other therapeutic interventions with children and adolescents were covered by Krener (1987). Discussions of family therapy can be found in Mrazek and Bentovim (1981) and of group therapy in Goodwin and Talwar (1989).

EXPLORATION OF HISTORY OF INCEST:

Clients may reveal histories of incest at any point in the course of evaluation or treatment either spontaneously or in response to the therapists' questions. **Proponents of each of the major approaches emphasize the importance of the opportunity to discuss the incestuous experiences with a therapist knowledgeable about psychological distress associated with incest and of attention to frequently manifested themes. Opinions differ, however, on the necessity for the client to address the incestuous experiences directly as part of the treatment.** For example, therapeutic focus on treating the incest directly and on the centrality of victimization in the lives of "survivors" of incest and other forms of sexual abuse requires, in the words of Summit (1989), "...the ability to recognize the central essence of assaultive betrayal and to explore the many threads of connection to basic character and emotional adjustment, as well as the determination to persist in that exploration despite historic protests arising within patient, therapist and society to deny those connections." Stone (1989) writes, "...more often the initial phase of 'treatment' will be preoccupied not so much with exploration, conflict-resolution, or other 'healing' interventions as with the gradual identification and revelation of the incest history." Stone adds the "...proviso that methodical exploration of the past, especially in the area of the sexual molestation, will prove too painful for many borderline victims of incest."

For therapists working from a medical model of etiology of mental disorders, a history of incest may be only one of several important contributing variables to a client's condition or may in fact be considered unrelated to the disorder for which the client has sought treatment. In-depth exploration of incestuous experiences may be encouraged only to the extent necessary to achieve symptom reduction and alleviation of specific disorders and may be less emphasized if work on other contributing factors (intrapsychic, interpersonal, environmental, or biological) leads to the desired results.

IMPEDIMENTS TO THERAPEUTIC ALLIANCE:

Proponents of each therapeutic point of view share concerns about potential impediments to the therapeutic alliance. They include possible mistrust, fear, and overeagerness to please on the part of clients with histories of exploitation by previous authority figures. Lack of mastery of reactions to accounts of incest and abuse and to angry, helpless, hopeless, or erotic feelings aroused by the client can impede the therapist's or counselor's ability to foster and maintain the alliance.

GENDER DIFFERENCES BETWEEN CLIENT AND THERAPIST:

Possible negative effects of gender differences between client and therapist on the development of the therapeutic alliance frequently have been cited as reasons for choosing female therapists for child and adult female clients with histories of incest. Such arguments tend to overlook the possibility that a woman or girl who has been sexually abused by a father or other related man and may thus have negative feelings towards men in general may also view her mother or other related women as responsible for having permitted the abuse. The client thus may have considerable anger, fear, and mistrust toward them. In the absence of clear data on those points, the wisest course seems to be to pursue the question of client-therapist matching by attention to each client's particular developmental level, previous experiences in helping relationships, and preferences rather than preconception.

Boundaries in Therapy

Proponents of varying perspectives agree in citing the failure to maintain clear boundaries between client and therapist or counselor as a major potential pitfall in working with a client who has a history of incest. The consensus is that the therapist should be tactful but firm in conveying in a consistent manner that the experienc-

ing of strong feelings, impulses, and memories may be part of the therapy. However, the translation of such feelings or impulses into physical expressions of affection or anger between the therapist and the client or of destructiveness toward the therapist's property are not. **In extreme cases, failure to maintain such boundaries may lead to sexual exploitation of the client by a therapist** who is willing to take advantage of the client's vulnerability to re-enactment of the destructive sequence of seduction, guilt, and fear of disclosure experienced in an earlier incestuous relationship.

Less-flagrant blurring of boundaries by acquiescence in the client's witting or unwitting attempts to draw the therapist into a nonprofessional relationship may lead to exacerbations of the client's anxiety and mistrust of the therapist and thus interfere in the achievement of therapeutic goals. Adherence to therapeutic boundaries with clients who may be initially prone to interpret such a stance as rejection or condemnation requires considerable skill on the part of the therapist and education of the client regarding the need to protect the therapeutic relationship.

Disclosure

Questions concerning disclosure of recollections of incestuous experiences by adult clients to involved members of the family of origin and pursuit of legal remedies for damages suffered through such childhood experiences have been increasingly discussed in the literature (Courtois, 1988). In the absence of clear guidelines on those points, **therapists are well advised to avoid dogmatic stances and to examine carefully with each client who is considering such steps the potential risks, benefits, and meaning.**

Outcome

Methodological limitations in studies of treatment of those with histories of incest are severe. They include small sample size, lack of inclusion criteria other than

histories of incest, frequent lack of external corroboration of such histories, wide variation in treatment approach, lack of agreement about goals, lack of agreement about outcome criteria, and absence of follow-up studies. **Treatments based on a medical model are able to draw on the broader foundation of increasing methodological sophistication in studies of outcomes of various treatments for specific psychopathologic disorders. Little attention has been given in the literature to potential negative effects of some currently advocated treatment interventions or to the natural history of syndromes said to be associated with incest.**

Prevention

Evidence is lacking regarding the efficacy of therapeutic approaches in preventing later development of mental disorder or psychological distress in those with histories of childhood incest who do not manifest signs and symptoms of mental disorder at the time of initial evaluation. Periodic reevaluations are indicated in children with recent histories of incest who are asymptomatic when first seen.

Summary

Available evidence strongly suggests that a history of incestuous experiences in childhood is associated with mental and behavioral disorders in several diagnostic categories (post-traumatic stress disorder, borderline and multiple personality disorders, and substance abuse disorder) and with various forms of psychological distress. Neither the nature of the association between incest and mental disorders, nor nosological reliability or validity for a specific "incest syndrome" or "sexual abuse syndrome," has been established. Information regarding treatment of men with histories of childhood incest or of adults who participate in incestuous relationships with other adults is sparse.

Therapeutic approaches that focus exclusively or mainly on "treating the incest," reversing the "centrality of victimization" in the client's life, or repairing a "dysfunctional family system" may place the client at continued risk for the morbidity and mortality associated with inadequately treated mental disorders. Approaches based on comprehensive medical and psychological evaluation and on established principles of treatment for specific disorders reduce this risk while providing the client with the opportunity to gain a deeper understanding of the meaning of the incestuous experiences at his or her own pace.

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QUESTIONS BASED ON THIS LESSON

37. Children or adults who report childhood experiences of incest/sexual abuse:

    A. Are extremely prone to the development of schizophrenic illnesses

    B. Are likely to manifest fear, anxiety, hostility, and inappropriate sexual behavior during the two-year period following the abuse

    C. Do not usually demonstrate depression, self-destructive behavior, feelings of isolation, low self-esteem, or a tendency toward "revictimization" as adults

    D. Always make up the victimization stories and these can never be substantiated

38. The worst outcomes vis-à-vis psychological disturbances among victims of childhood sexual abuse are seen in those who:

    A. Experienced very short-lived sexual abuse experiences

    B. Were victimized by total strangers

    C. Were subject to more than a single incidence of abuse, particularly at the hands of a father or stepfather

    D. Received substantial family support

39. Which of the following statements is correct?

    A. Histories of childhood incest are common in clients who report sexual involvement with their therapists

    B. Multiple personality disorder, borderline states, and post-traumatic stress disorder are never found among victims of incest

    C. Most states do not require by law mandatory reporting by health and other professionals of suspected cases of intrafamilial sexual abuse

    D. Freud has not been criticized for attributing genuine instances of incest and childhood sexual abuse to pure fantasy

40. Which of the following adult behavioral themes is not a particularly common residue of childhood incest/sexual abuse?

A. Mistrust of the motivations of oneself and others

B. Frequent testing of interpersonal boundaries

C. Stunting of social skills development in favor of using seductive behavior or intimidation

D. Auditory and visual hallucinatory states with disorientation

Directions in Mental Health Counseling

VOLUME 2 • LESSON 11

Anorexia Nervosa, Bulimia Nervosa, and Depression: Multiple Interactions

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VOL. 2, NO. 11

November 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING (ISSN # 1062-0788, USPS # 008-015) is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

Is there an important relationship between affective disorders, particularly depression, and eating disorders such as anorexia nervosa or bulimia nervosa? These two eating disorders are quite different, although they may overlap. The anorexic client is usually without direct expression of painful emotions; by contrast, the bulimic client is usually extremely distressed, trapped in the struggle to combat overpowering urges to binge on food and then purge the body of what has been devoured.

Consider anorexia nervosa first. Such clients seem to demonstrate a connection to depressive symptoms in four ways:

- starvation induces depression
- a depressive mood often initiates the dieting behavior
- weight gain unmasks an underlying depressive state
- or, depression and episodes of anorexia may occur independently throughout the history of such clients, arising, from similar psychodynamic origins

The implications for treatment are clear. First, attempt to restore weight; this tactic often restores mood. If, however, depressive symptoms appear after weight gain, the use of antidepressant medication (in the context of total therapy) is indicated.

Affective disorders appear to be frequent in the families of both bulimic and anorexic clients. Bulimic symptoms seem to regulate depressive symptoms in a number of clients. Combining psychotherapy with antidepressant medications can provide a significant opportunity for improvement.

Purely mechanical or strictly behavioral approaches to these disorders often leads to emergence of a depressive component; such treatment strategies should not be used without due attention to key psychodynamic issues.

Introduction

How are eating disorders and mood disorders related? Are anorexia nervosa and bulimia nervosa variants of depressive illness? Considerable controversy about these issues exists from both a theoretical perspective and in regard to implications for clinical practice. The following discussion attempts to integrate recent research efforts in this area and to summarize a pragmatic approach to client care. The first generally accepted report of anorexia nervosa was made by Morton in the late seventeenth century and described "violent passions of the mind" in his patients. Gull and Lasègue, in almost simultaneous reports in the nineteenth century, initiated the modern era of the understanding of eating disorders by their description of the psychopathology and behavior characteristics of anorexia nervosa. They too remarked on the distressed mental state of these clients (Andersen, 1985*a*).

The best clinical research on the relationship between starvation and mood derives from the landmark work of Keys and his colleagues (1950) in the late 1940s. Incidentally, their study was conducted without specific regard to increasing our understanding of eating disorders. Male conscientious objectors underwent losses of almost 25% of their body weight through semistarvation in a study of the global effects of starvation and subsequent methods of rehabilitation. This study clearly demonstrated that starved human beings become apathetic, anhedonic, and asocial. Until recently, the depressed mood of clients with anorexia nervosa has been attributed to the nonspecific consequences of starvation, supported by the work of the Keys group.

The simple picture of starvation as the cause of depressive symptomatology started to unravel when Cantwell et al. (1977) and Gershon and colleagues (1984), among others, found a substantial increase in the incidence of depressive illnesses in the relatives of clients with anorexia nervosa. This raised the question of whether anorexia nervosa was in fact a variant of depressive illness. The hypothesis

that anorexia nervosa causes depression became reversed, and the idea developed that depression causes anorexia nervosa.

Bulimia nervosa was first described less than two decades ago in a subgroup of patients hospitalized for anorexia nervosa. Several investigators observed that approximately 40% of hospitalized anorectics also suffered from binge-eating followed by purging. When this group of starved bulimic clients was investigated, it soon became clear that **bulimia nervosa existed not only as a subgroup of anorexia nervosa but also could be found in a large number of individuals with normal weight who had never manifested anorexia nervosa.** The discovery of **increased affective disorders in the families of these clients** was noticed and the hypothesis developed that perhaps bulimia nervosa, as well as anorexia nervosa, was a variant of mood disorder (Hudson, 1984).

Two additional developments furthered the idea that mood disorders cause eating disorders. First, several investigators reported that **antidepressants decreased bulimic symptoms**, probably independent of their effect on mood. Pope and Hudson (1984) and others described this antibinge effect using tricyclic antidepressants while Walsh (1984) conducted trials with monoamine oxidase inhibitors. Secondly, a **number of investigators looked at the lifetime incidence of mood disorders in clients with anorexia nervosa or bulimia nervosa and found a high incidence in these same clients as well as in their relatives.**

The controversy is perhaps best appreciated by reading back to back the reports of Johnson-Sabine et al. (1984) and Hudson et al. (1983). The authors of the former article state fairly confidently that depressive symptoms in clients with bulimia nervosa, for example, are nonspecific consequences of their abnormal behaviors, whereas in the latter article the authors suggest that mood disorders may be integrally related to eating disorders. The basic questions to be answered are: **(1) What is the mood state of clients with eating disorders? (2) What *kinds* of depressive syndromes do they**

have? (3) What is the *causal* relationship between eating disorders and mood disorders? (4) What are the *implications* for treatment?

A famous scientist is reported to have said something similar to the following: **Make things as simple as possible but no simpler than they actually are.** This remark applies to the interaction between mood disorders and eating disorders. The controversy about which disorder is primary and which is secondary becomes moot when the subject is no longer viewed as an "either-or" issue but rather as a "both-and" situation. In fact, mood disorders and eating disorders are related in a complex multidirectional way. These relationships are perhaps best discussed separately for each of the conditions, anorexia nervosa and bulimia nervosa.

Anorexia Nervosa

Anorexia nervosa and depressive symptoms have at least four kinds of interactions. The observations of Keys and colleagues (1950) are as valid today as when they were first made. Starved clients do, in fact, go into a depressed mood; there is little emotional expression and remarkably little joy and warmth. **They differ, however, from clients with classic mood disorders in that they seldom have true psychomotor retardation, early morning awakening, or delusions of guilt or self-blame. They generally lack the agitated depressive state of the handwringing, melancholic client. They do share with other depressive syndomes a low mood and lack of emotional responsiveness.**

A second, opposite, direction of cause and effect occurs when mood change leads to anorexia nervosa. **A depressed mood—though not necessarily a depressive syndrome—often initiates the dieting behavior that leads to anorexia nervosa.** Attempts to diet generally begin during a time of personal demoralization and dissatisfaction with body size and shape. This second kind of interrelationship, a depressed mood state as ***a cause*** for the behavior leading to anorexia nervosa, highlights the fact

that abnormal eating behaviors may serve as methods to regulate dysphoric mood state.

A third relationship exists between depression and eating disorders that may be uncovered only during treatment. **When anorexia nervosa symptoms serve as an unstable but nonetheless temporarily effective way of dealing with depressive symptoms that arise from unresolved developmental crises, then inadequate treatments that emphasize weight gain alone will unmask the depressive symptoms. Removal of the anorexic symptoms without resolution of the central psychodynamic conflict may uncover but not resolve depressive symptoms.**

Lastly, depression may appear during the life of clients with anorexia nervosa without being causally related to anorexia nervosa, because both depressive illness and eating disorders share common predisposing factors of a vulnerable temperament and a genetic contribution.

This fourth kind of interaction raises another fundamental question: **Why *is* there an increased incidence of mood disorder in the relatives of clients with anorexia nervosa or bulimia nervosa?** The following is our hypothesis based on the evaluation and treatment of several hundred clients using the Johns Hopkins Phipps Psychiatric Service. An increased incidence of mood disorders occurs in relatives of clients with anorexia nervosa for two reasons. First, **families with affective spectrum disorder generate an increased frequency of the vulnerable personality that is most predisposed to the development of anorexia nervosa.** The vulnerabilities that are essential requirements for the development of anorexia nervosa include **low self-esteem, an obsessional style of dealing with problems, and the incorporation of external sociocultural or familiar ideals as a way to gain role definition rather than growth from inner ideals.** The second way in which these families contribute to the development of eating disorders is **by generating, by definition, a high frequency of dysphoric mood states which eating disorders may then serve to**

regulate via the alteration in neurotransmitters which these behaviors produce. The multiple causal relationships between anorexia nervosa and depressive symptoms are summarized in Table 1.

TABLE 1

Multiple relationships between affective disorders and anorexia nervosa: complex cause-effect interactions

- Depression in anorexia nervosa most frequently occurs *secondary* to the eating disorder
- Depression may be *primary*, with anorexia nervosa occurring to alleviate the depressive symptoms
- Depression may be *tertiary* and represent a psychodynamic response to increased weight and the loss of a coping mechanism which had been used as a short-term method to deal with developmental crises
- Depression and anorexia nervosa may be *independent* and represent common risk factors: vulnerable personality and genetic loading

Bulimia Nervosa

As with anorexia nervosa, there are multiple kinds of interactions between bulimic symptoms and mood disorders, and these are summarized in Table 2. Every clinician caring for clients with bulimia nervosa has noted that **these are individuals who feel out of control and are demoralized by their binge-purge behavior.** DSM-III-R (American Psychiatric Association, 1987), in fact, notes that disparaging self-criticism and a depressed mood often follow eating binges. Bulimia nervosa cannot at all be used to describe the behavior of jaded Roman gourmands who gorged on course after course and vomited to prepare the way for more food. **Bulimics are people who are enormously distressed by their behavior and very seldom consider it ego-syntonic.**

The next kind of causal connection occurs **when depression causes bulimia nervosa.** We noted this by listening to **clients treated for mood disorder who told us after improvement of their depression that nondisclosed symptoms of bulimia nervosa had also improved as well as their mood when they were given tricyclic antidepressants.** Careful psychiatric histories of these clients showed that **bulimic symptoms serve to regulate a depressed mood state.** Whether this regulation is seen in psychodynamic terms as a mastery technique or in behavioral terms as a coping mechanism, or whether it changes neurotransmitter levels, is a matter of conjecture. Probably all these mechanisms occur. The fact is that binge behavior may help elavate low mood,and the behavior is perpetuated by classical operant conditioning techniques.

A concern to psychodynamically-oriented practitioners has always been the avoidance of symptom substitution. In treatment for bulimia nervosa, clients whose binge-purge behavior is decreased without attention to purposes they serve may experience previously hidden depression because their behavioral mechanism of mood regulation has been removed. This uncovered depression may lead to alternative mechanisms of mood regulation such as alcohol abuse, other kinds of drug abuse, or self-injury. As well, bulimic clients may have mood disorders independent of their

TABLE 2

The relationship between depressive symptoms and bulimia nervosa: multiple possible kinds of interaction

- Most commonly, depression is *secondary* to feeling out of control and helpless
- Not infrequently, depressive symptoms are *primary* and precipitate bulimic behavior by operant-conditioning principles because the binge-purge cycle may temporarily help dysphoric mood states
- A *tertiary* interaction is possible: interrrupting bulimic symptoms may uncover a depressive state when a method of mastery, coping, and probably neurotransmitter change is taken away. It may be prevented or treated with appropriate psychotherapeutic, behavioral, and pharmacologic methods
- Common etiologic factors may *independently* produce depressive symptoms during the lifetime of the patient

eating disorder because of their vulnerability toward the independent expression of each of these syndromes on the basis of a predisposed temperament and genetic loading. The vulnerable personality in bulimia nervosa may include more self-dramatizing and "borderline" features than in anorexia nervosa, as well as the shared low self-esteem and obsessional style. The multiple interrelationships between bulimic symptoms and depressive symptoms are described in Table 2.

Implications for Practice: Anorexia Nervosa

Our experience suggests that **the low mood that accompanies the starvation of anorexia nervosa is best treated by prompt nutritional rehabilitation. Restoration of normal body weight often, but not always, alleviates the anhedonic, depressed mood. If weight restoration and intensive psychotherapy do not improve mood, and if clients meet DSM-III-R criteria for major depressive disorder, then vigorous treatment to therapeutic blood levels with an antidepressant is warranted. There is, unfortunately, no evidence that antidepressants are uniformly beneficial for all food-restricting anorectics unless they have associated symptoms of mood disorder at restored weights. When anorexia nervosa appears to be the result of initial depressive symptoms, rather than the cause of them, then antidepressants may be employed sooner in treatment and continued for 6-9 months after weight restoration.** We generally start with nortriptyline (Pamelor) because it can be easily measured in the blood and has a moderate number of side effects. **Any of the standard tricyclics may be used.**

The uncovering of depressive symptoms by a purely behavioral or mechanical approach toward refeeding can be avoided by planning a comprehensive approach toward treatment. This means attending to the psychodynamic aspects of anorexia nervosa, the social and familial consequences of the disorder, and the psychopathological characteristics of fear of fatness, pursuit of slimness, and perceptual distortion. **The goal of therapy is to make this disorder unnecessary rather than to take it away**

(Andersen, 1985*b*). **The goals sought by clients who develop anorexia nervosa are usually desirable, understandable ones. We tell clients that we endorse their goals,** such as feeling better about themselves and being more effective, **but ask them to work with us to find more adaptive, less harmful methods to accomplish these goals.** This means developing a therapeutic alliance with their observing ego, employing the resources of the healthy, rational part in order to deal with the symptoms and behaviors of the illness. **Decrease in symptomatology is only a part of the treatment of anorexia nervosa. The encouragement of normal growth and development, especially the capacity to identify and deal directly with developmental challenges and to experience positive mood states, are major goals of treatment.**

Much remains unknown about the long-term consequences of anorexia nervosa. Our observations suggest that when clients do improve, they may remain vulnerable to repeated episodes of the eating disorders and may experience a variety of the syndromes clustered under the term "affective spectrum disorders " including obsessive-compulsive symptoms, frank depressive episodes, dysthymic disorders, and alcoholism. Hall et al. (1984) found that 50% of clients with eating disorders developed another psychiatric syndrome on follow-up.

Implications for Treatment: Bulimia Nervosa

We employ methods similar but not identical to those used in anorexia nervosa in clients suffering from bulimia nervosa. **Initial efforts are directed at interrupting the binge-purge behavior to alleviate the demoralization that comes from being out of control.** Regular, balanced meals are prescribed, with adequate intake of complex carbohydrates, and the avoidance of food fads. Weight change is undertaken, if necessary, only slowly, and after food intake is regular. Psychotherapy begins with supportive and educational methods but soon incorporates cognitive and psychodynamic techniques. **Whereas anorexic clients often have difficulty in identifying their mood state, bulimic clients may experience a diffuse dysphoria**

which they find intolerable and which had been alleviated only by binging. Clients work in individual and group therapy to identify specific moods states, to tolerate their presence for reasonable periods of time without short-circuiting the mood with a "food fix," and then to find specific methods to deal with the dysphoric mood that get at the symptom or its cause in healthy ways.

The data are not yet clear as to whether antidepressants effectively decrease binge-behavior independent of mood state. Somewhat exaggerated claims have been made for their effectiveness, sometimes leading to the prescribing of these medications as the complete treatment for bulimia nervosa. **Many clients are relieved of their bulimic behavior by a combination of behavioral methods and cognitive psychotherapy techniques, without any medication. When antidepressants are used, they should be employed as part of a comprehensive treatment program that includes psychotherapy and attempts to deal with the social and familiar aspects of illness.**

A history of clear depressive episodes initiating binge episodes suggests that long-term treatment with antidepressants may be beneficial. As with any depressive illness, **lithium supplementation or a switch to a monoamine oxidase inhibitor in place of a tricyclic may be warranted. There is little evidence that the newer antidepressants are clearly superior.** Documented blood levels within a therapeutic range of 4–6 weeks are usually necessary to make a judgment about the effectiveness of an antidepressant.

The two major causes of death in clients with eating disorders are starvation and suicide for anorexia nervosa, and cardiac disorders and suicide for bulimia nervosa. Clinicians will, therefore, be attentive to mood state, and possible suicide in these clients, as in all individuals with depressive symptoms (Garner, et al., 1984). The more impulsive suicide attempts that are found in bulimic clients with personality disorders characterized by impulsivity are harder to predict and are less responsive to medications.

Summary

Mood symptoms are found in most, if not all, clients with anorexia nervosa and bulimia nervosa. The practicing clinician should best avoid taking a single view of the relationship between these disorders and appreciate instead the complex, multiple, possible interactions. Even though anorexia nervosa may have ego-syntonic features with a false sense of mastery, it is usually always associated with a lowered mood state, a major contributing feature being the starved state. Bulimia nervosa symptoms are frankly ego-dystonic in the great majority of clients and a source of demoralization and depression. Prompt treatment of the underlying starvation in anorexia nervosa and the binge-purge behavior in bulimia nervosa improve mood in a majority of these clients. **Where the symptoms have served to regulate dysphoric mood states, then direct treatment of the lowered mood with antidepressants as well as psychotherapeutic methods may be helpful. Purely mechanical or strictly behavioral approaches to these disorders may lead to the uncovering of depressive symptoms regulated by the eating disorder.** Anticipation of this possible consequence with a comprehensive treatment program will often prevent this state ordeal with it as it occurs. Finally, the factors common to the origin of both eating disorders may lead to independent expression of a variety of syndromes associated with affective spectrum disorder over the life span of a client. Ongoing research studies that are exploring the interrelation between mood disorders and eating disorders will lead, it is hoped, to an appreciation of the variety of mood states that occur in clients with anorexia nervosa or bulimia nervosa, a better understanding of the syndromes to which these mood states belong, and effective long-term treatment.

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QUESTIONS BASED ON THIS LESSON

41. Who gave the first generally acceptable report of anorexia nervosa?

    A. Adolf Meyer

    B. Keys

    C. Morton

    D. Freud

42. Bulimic clients:

    A. Lack a family history of affective disorder

    B. Are singularly unconcerned about their behavior and predicament

    C. Do not respond to antidepressant medications

    D. Are usually quite distressed by their behavior

43. Which of the following statements is correct?

    A. If restoration of normal body weight in an anorexic client is not accompanied by depression, antidepressants should automatically be employed on a prophylactic basis

    B. The low mood of the anorexic client who has lost a great deal of weight is most effectively attacked by psychotherapy alone

    C. When depression is associated with bulimia nervosa, antidepressants can be used with considerable benefit

D. Since many anorexic clients have goals, such as being slim and attractive, is it essential that the therapist take such goals away entirely

44. In the treatment of bulimia nervosa:

A. It is not clear as to whether antidepressants effectively decrease binge behavior independent of mood state

B. Clients are never relieved of their behavioral symptoms by behavioral or cognitive therapy

C. Lithium or monoamine oxidase inhibitors should never be used

D. The two major causes of death are starvation and suicide

Directions in Mental Health Counseling

VOLUME 2 • LESSON 12

Divorce as a Developmental Catalyst

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VOL. 2, NO. 12

December 1992

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DIRECTIONS IN MENTAL HEALTH COUNSELING is published monthly for $195 per year by The Hatherleigh Company, Ltd., 420 East 51st Street, New York, NY 10022. Second-class postage paid at New York, NY and additional mailing offices. POSTMASTER: Send address changes to DIRECTIONS IN MENTAL HEALTH COUNSELING, 420 East 51st Street, New York, NY 10022.

EDITOR'S NOTE

In this day and age, when divorce has become a common occurrence—one that is seemingly associated with less social stigma than once surrounded it—you might think that people going through the dissolution of relationships would be much less prone to the agonizing emotional consequences. There are many reasons why this is not so. In this lesson, the author examines the profound effect of divorce on self-esteem, giving equal balance to intrapsychic factors such as loss, loneliness, the sense of failure and humiliation, and the realistic factors, such as the collapse of a financial and social lifestyle and the vulnerability of the parties to a wide variety of new stressors including a lowered standard of living, seduction, bad legal advice, and rejection by family and friends.

Although the issues cited may seem very familiar to us, the execution of therapy with people undergoing divorce is a serious challenge. Only by keeping the multiplicity of influences in mind can the therapist deal rhythmically with intrapsychic conflicts, realistic problems as they arise, and the need to resolve grief, guilt, and rage, and his or her own countertransference risks.

Divorce represents a singular opportunity for chronic unhappiness, resentment, and emotional disability on the one hand, or personal growth and reintegration on the other. The outcome will not only influence the health of the partners, but have a profound influence on the well-being of their children as well.

Introduction

During the 1930s, psychological thinking in North America was influenced greatly by the psychosocial approach taught by Adolph Meyer. Later, in the 1960s and '70s, Erikson developed a life cycle framework that viewed personal psychological growth in stages. Now, with the increase in knowledge in biochemistry and genetics, many use the biopsychosocial approach to formulate the etiology of mental illness and its treatment. In addition, we have been made aware of the impact of life events upon a person's mental health and ability to function socially and occupationally. One of the most stressful and common life events is divorce, which has been rated second only to the death of a spouse in severity by one scale that measured 43 different events, and tenth out of 61 events by another (Holmes & Rahe, 1967; Raykel, Prusoff, & Uhleuhuth, 1971).

The divorcing person who presents to the mental health professional usually complains of depression and anxiety. Counseling must involve a variety of factors: consideration of the immediate practical problems involved in the divorce situation, and uncovering of the intrapersonal and interpersonal functioning that led to the situation. Thus, divorce, a painful life event, can be seen as providing a therapeutic situation that uses all of our present knowledge and skills. Furthermore, therapeutic intervention can go beyond the situation disorder to an insight-oriented psychotherapeutic approach that will work toward the attainment of personal maturational growth. Divorce can then become a catalyst for positive change rather than remaining a pain-filled stressor (Gold, 1988).

The psychological stages of reaction to separation and divorce can be delineated in a general manner. Such a framework lends clarity to the process and aids the therapist in understanding how the client is proceeding through the situation, the present stage, and the rate of progress.

Initial Stage

A couple who decides to marry does so, usually, with the expectation that the marriage will last a lifetime. Indeed, many who live together without having gone through a legal ceremony have the same expectation. The reactions to the breakup of a relationship are similar in both instances. **Our social system emphasizes the adult couple, and a sense of identity is bound up with a view of oneself as a single person or as part of a dyad.** From the time of young adulthood, it is difficult to go out alone for many who are uncomfortable with being single. The person who does not marry or form a long-lasting relationship is thought of as unusual and different by most in middle-class societies. **Once a person becomes known as part of a couple, the association becomes an integral part of self-identity and self-esteem.** The dissolution of the union, therefore, has deep personal repercussions.

Following the breakup, many will say they feel they have failed to make the relationship continue. They feel rejected and thus humiliated, and they believe all can see their shame and worthlessness. **The intense feeling of loss is associated with an almost childlike sense of helplessness;** reactions often include angry crying that is later supplanted by withdrawal and denial. **The feelings differ from those following a spouse's death because they are accompanied by a strong sense of rejection.** Previous experiences with feeling rejected, of course, may shape much of their present reaction, which is also colored by their view of how they are perceived by society.

Most breakups are precipitated by one person, despite prior indications that all was not going well. The other may be surprised and feel disbelief. **Occasionally, there is relief, which is accompanied by feelings of freedom and loss of the obligation to consider the likes and dislikes of the other.** The decrease in tension is often reflected in the attitudes of any other household members. However, most couples do

not maintain that initial tranquility for more than a few days or weeks—a terrible feeling of loneliness begins. This loneliness can become pervasive and alternate with bouts of crying; later, periods of loneliness may be interspersed with rages that may be shocking to the self. The person feels even more helpless and he or she questions his or her ability to go on. The loneliness seems unbearable, and it is that complaint that many find the worst aspect of the separation. Weekends and holidays are especially difficult.

In the initial stage, the person will have difficulty sleeping, concentrating, and attending to work-related details. Decision-making is difficult. Thoughts of the partner and the relationship become obsessive. Those who have separated feel depressed, find themselves unable to cope, and wonder if they are relying too heavily on friends and family for support. They fear eventual rejection by those same people as they grow weary of their story and reject them also. They replay the events of the marriage endlessly, looking for ways things might have been done differently, and blame themselves. Certain that they will never care for another again, loneliness both sets off and is a product of such ruminations. This intense stage may last as long as several months. Six factors determine the length: prior socialization, the psychological effects of the marriage itself, dependency needs, financial considerations, child custody concerns, and legal matters.

PRIOR SOCIALIZATION:

People marry for many reasons.

• ***Security and strong dependency needs***. Security and dependency are closely linked. Some require the social safety and well-being of a traditional marriage rather than being alone and self-reliant, so they give up personal responsibility and depend upon another for their support. That dependence may include subservi-

ence and relinquishing all personal feelings and ideas in return for being taken care of. Dependency can vary in degree from time to time within any marriage.

• ***Escape***. Marriage can be seen as a refuge from an unpleasant or abusive home, an unsatisfactory job, or other difficult living arrangement. When viewed as an alternative to self-support, marriage is interwoven with dependency and security needs.

• ***Arrangement***. Arranged marriages still occur within some cultures and families, even in North America. Although a person may have some degree of choice, the final decision belongs to the parents.

• ***Social pressure***. As mentioned earlier, our society expects people to marry. Social interactions become increasingly restricted as people grow beyond the adolescent years because most activities are organized for couples. The pressure to marry is exerted by friends and family, even when a couple has been living together for a long time.

• ***Pregnancy***. An unexpected pregnancy may precipitate a marriage, or it may be used to force a marriage. The motivation may or may not be conscious.

• ***Desire for a child***. Some do not find single parenthood acceptable and marry when they want to have a child. The spouse may be a long-time lover or someone chosen as an acceptable parent and gene provider.

• ***Unconscious needs***. The unconscious needs of a person are bound up with many of the preceding reasons. The choosing of a mate is a comfortable decision, and the reason why that is so may become apparent only when the marriage is falling apart.

• ***Love and completion of oneself***. There are many definitions of love, and the feeling of being in love can combine with any of the other factors mentioned. According to

Erikson (1968), the young adult is ready to share intimate feelings and behaviors with another while maintaining his or her own sense of self. This lays the basis for a firm commitment.

Once married, the couple learns to live together. Most newlyweds are unaware of the compromises, consideration for the other, and degree of cooperation needed. They have not thought beyond the marriage ceremony and "living happily ever after." Research and clinical experience have demonstrated **that men and women develop their capacity for intimacy differently** (Gilligan, 1982). The man marries with the desire to share his life with his wife, but **he is often unprepared to curtail his other activities to satisfy his wife's expectations** or to fulfill the responsibilities marriage requires. Often, his own needs remain paramount, and he can find it difficult to adapt to hers—and later those of a child—on a daily basis. **The young woman may feel a need for an intimate relationship before she develops a strong ego identity**. She sees herself developing a firm self through her marriage, expecting to be totally involved in her life with her husband. Obviously, such **differing initial expectations** can lead to clashes, and the couple may not be prepared—or be able—to work their way through them.

Financial, family, and occupational concerns add to the pressures of life together. The couple must learn to resolve their problems despite all those influences, while each continues their individual growth. All of this can become a difficult task. At this point, their earlier perceptions of marriage and marital roles become important, because some may turn out to be different in practice than they were expressed in earlier discussions. Living together may alter theories of daily responsibilities. **Becoming parents** may change theories of childrearing responsibilities. Furthermore, the **expectations of each other's roles may diverge and be influenced by society's**

views of how the husband and wife should behave. Thus, early plans to divide housework may disintegrate practically or dissolve with the birth of a child. For example, maternity leave is more socially acceptable than paternity leave. Similarly, the mother usually can stay home from work with an ill child, whereas the father generally cannot. Roles slowly become more traditional, and if the partners do not acquiesce, difficulties can arise quickly. The changes are often insidious and desired by neither but are not discussed or challenged unless one becomes overtly unhappy and is willing to bring up the matters.

Many believe that once married, they must remain married, and their families have the same expectations. Attempts to discuss their problems with parents may be met with hostility and lack of sympathy or support. If the marriage does break up, the ex-partners may or may not find support from their families, so their sense of rejection may increase.

Thus, the reasons for entering the marriage and the expectations of its demands will have a strong influence on the person's reaction to its dissolution.

PSYCHOLOGICAL EFFECTS OF THE MARRIAGE ITSELF:

The degree of loss of self-esteem that results from the end of a marriage depends upon the person's self-concept and the degree to which that self-concept was bound up in the marriage. If the marriage itself was marked by profound belittlement, self-esteem may be shaky already. When the marriage ends, a person may have few internal resources to call upon if he or she has been belittled by long-term assault on his or her behavior, thoughts, and reactions. Such a person may find it hard to believe that he or she can survive without his or her mate, and, consequently, may experience self-denigration.

A marriage that has provided little affection or attention also decreases self-worth. The person may feel unlovable, and after years of neglect find it hard to believe that anyone could care.

The marriage that lacked support and was filled with conflict and deceit may result in depression from the loss of self-esteem and the constant battering from crises. The inability to express anger and resentment at the spouse's behavior during the marriage can cause anxiety and panic attacks. Those symptoms can precede the separation itself.

DEPENDENCY NEEDS:

Dependency, which is one reason for marriage, may also grow and develop during the marriage from the personalities involved and the demands of both the relationship and external factors. For example, women often grow to depend on marriage for support of self-esteem and may see their worth based on the role of wife and mother. When that stage is removed, self-esteem often crumbles: gratification came only from the role within the marriage, whether she worked outside the home or not. For such a woman, divorce will be shattering.

Some men view marriage to some degree as a reflection of occupational-financial achievements, with the wife being part of a picture displayed to the world. In such a case, divorce dissolves a vision and may prove financially damaging. Anger at these events may be rationalized by claiming that the ex-partner will make ruinous financial demands, but this may in fact conceal fury at the destruction of his self-image and how he is perceived by others. The man may be surprised and alarmed to realize how much he had unknowingly depended on his wife, how much her behavior and approval shaped his self-image, and how important it was that others knew *this* woman was his wife.

The woman, in particular, may believe that only through the traditional role of wife can she survive. She may believe she is not competent to take care of herself and may fear independence and self-sufficiency and be panicked by the realization she is now on her own. She may not know how to begin to take care of her financial and practical needs, and that realization may overwhelm even her emotional needs.

FINANCIAL CONSIDERATIONS:

Concerns about money are often very real to the newly separated. For the person suffering from low self-esteem, it is a difficult time to make necessary—and often permanent—decisions. Some ask for nothing, out of guilt or fear of confrontation, and disregard their future. Others continue their passive dependency and believe their spouse will be fair in the division of their assets, or that the breadwinner will continue to provide as always for the ex-spouse as well as the children.

The woman who has not worked outside the home for years may find it necessary to do so now. Her training may be obsolete or non-existent at the same time she must establish her own credit rating, obtain her own accounts, and pay the bills. She may have all the child and household expenses but little of the money.

At this early stage of separation, it may be difficult to find the ego strength to fight for oneself. In fact, anger and hurt may make either or both ex-spouses unreasonable. The departed spouse may hide guilt, project responsibility for the divorce onto the other, and use money as a weapon. As a result, the children may be overlooked, and the breadwinner may refuse to support them financially, justifying the behavior by expressing a desire to withhold money from the ex-spouse.

CHILD CUSTODY CONCERNS:

The children become part of the reaction to divorce. **Either spouse may use the issue of custody in an attempt to wound the other or enhance self-esteem. Often, what is best for the child is ignored** as the perception of the other is extended to the parenting ability of the other. This dispute takes place when ego strength is low and personal resources are taxed. The custodial parent is often concerned about the effects of custody disputes on the children.

If the mother is awarded custody, she may be embarrassed because they see her humiliation and coping difficulties. **The children may develop problems in school, display behavior maladjustments, worry about their mother, become angry with one parent, or show general rebelliousness. Somehow, she must care for them, resolve her own practical needs, and deal with her feelings of loneliness and rejection.**

THE LEGAL PROCESS:

Legal issues affect the reaction to divorce. Ideally, both persons obtain a lawyer and receive good advice and service. **Often, one cannot afford a lawyer or tries to use the same lawyer as the divorcing spouse, thinking all will be easily resolved. One or both may be too dependent upon and noncritical about the advice given by the lawyer.** Such a scenario is likely to happen to a woman who is fearful and lacking in confidence. The legal system may be used to harass or punish the other spouse out of injured pride and fury. **Many are unable to cooperate with their lawyer because of their own psychological symptoms** and find it impossible to make a reasoned decision (Willimans, 1988).

Thus, the initial stage of divorce is complicated by many factors that are extraneous

to the interpersonal disruption and yet integral to it. The more complicated the factors and the more unyielding the other spouse, the greater the difficulty in resolving the earlier reactions.

Middle Stage

During the middle stage, **each of the former partners develops the self-image of a separate person, detached from the marriage and the former mate**. Slowly, **reliance on friends and family often lessens**, either because of a sense of being burdensome or because of uncertainty about their loyalty. The unattached individual feels like an "extra person" at social functions. The relationship with the spouse may continue to be marked by disputes, or the former couple may have some friendly meetings. Loneliness may lead to spending a night or weekend together, but then the fighting resumes with escalated ambivalence and anger.

Either member of the separating couple may quickly become involved with someone to bolster self-esteem, and the relationship may become intense before separation from the former partner is psychologically complete. Later, the new relationship may appear to be a repetition of the old, but it provides needed emotional support and reinforcement following the separation. Otherwise, loneliness continues and something seems to be missing. No one is at hand with whom to share on a daily basis and no one is available to help with child care or other responsibilities. The single parent feels overburdened, with no evenings or days off. **The parent who has custody of the children may feel rage toward the former partner, whose life appears carefree**. Because most of those who provided the primary financial support before the breakup do not continue to provide for the children, the **financial struggles may be intense**. A lower standard of living commonly results.

While trying to regain a sense of identity and self-esteem, some of the battles with the practical concerns of daily living force an awareness of any inner strengths, whereas others cause a feeling of helplessness. However, self-reliance develops slowly. The anger remains, though it may be sporadic, and it is easily renewed at each encounter with the former spouse. A variety of physical complaints may emerge as well. The middle stage may take several years to resolve. The stages of divorce are like those of mourning: shock, denial, rage, blame, and—eventually—acceptance and resolution. The legal process can hasten or delay the transition from one stage to the next.

Resolution

Resolution is the most important stage for the future mental health and well-being of the separated person. Many never reach it and instead remain angry and resentful. Others turn to therapy. In general, women find asking for assistance easier than men, but either partner may seek treatment during or after the dissolution of the marriage.

The initial symptoms may be depression or anxiety, which may or may not be consciously related to the marital situation. Some ask for symptomatic help only, whereas others request therapy to avoid repeating past behaviors or to understand what is happening. Therapy can be limited to medication or crisis intervention, or it can be directed toward insight and change.

The therapist must be familiar with the various reactions to divorce and be aware of the many realistic problems associated with custody, division of property, and the newly-acquired single status already outlined. As always, the person's methods of coping and reacting determine the course of therapy, with the addition of the separation process in both its psychological and practical aspects.

Thus, therapy moves from the presenting situation to a more detailed probing of life-long patterns of relationships and underlying conflicts, and focuses on restructuring them into new, healthier interactions. The focus, then, is interpersonal change, using the divorce process as a catalyst. Traditional models of psychodynamic psychotherapy can be adapted to that circumstance.

Earlier narcissistic injuries can be discovered through history taking, and characteristic reactions to them can be examined. Family relationships and friendships must be explored, as well as the development and substance of prior identity formation. The concepts of marriage and marital roles are discussed and the evolution of the marriage from initial meeting to breakup are examined. Throughout the explorations, the person's typical manner of dealing with the stress and with interpersonal interactions becomes evident.

As all of those aspects of the self are becoming clearer, daily concerns and crises continue to arise and must be dealt with as part of therapy. A balance must be kept between support and reassurance and the work of therapy. Thus, a legal or financial problem can form the basis of a session, as the therapist works with the client toward understanding the reactions and coping methods that, in that instance, are part of characteristic behavior. The client can then learn more effective techniques or responses. Some may need to learn and practice assertive techniques as an aid to boosting their low self-esteem.

Loneliness can be overcome by using community resources and support groups to develop new friendships. The therapist can assist by pointing to such resources and encouraging their use. Again, the client's responses to interactions in the new situation are used in therapy sessions. Referrals may be made to employ-

ment counselors and agencies, educational facilities, or social assistance offices. The therapeutic process incorporates them and is not sidetracked by them. The lonely, dependent person must deal with those emotions in therapy; transference issues should be dealt with constantly and thoroughly. **The therapist must not replace the spouse of a previously dependent individual, nor should the therapist's values replace those of the family.** Instead, the person is assisted toward developing personally-determined beliefs and ego strengths.

The **feeling of failure** must be addressed. For many women, for example, being good and nurturing meant they would be rewarded with love. Divorce meant that they had failed to be good enough and therefore deserved rejection. That is a combination of social role learning and primary process thinking. Adult reasoning may point to her own illogic, but hurt and anger remain. As a result, many sessions may be needed to work through that problem. **The rage expressed must not be mistaken for that of the borderline personality; instead it should be seen as part of the divorce reaction conditioned by prior socialization.** Her feelings can then be examined in terms of injured self-esteem, loss of self-control and mastery, and disappointment in her loss of a dream of "living happily ever after." In that way, **her self-concept evolves from the introjected values of childhood and those gained during the marriage and from society into a more accurate assessment of her self, her own values, and her needs.** This assessment is heightened by the manner in which she is treated on a social level as a divorced woman: her encounters with authority figures such as bank managers and employers; the sexual overtures from friends, relatives, strangers—even professionals whose help has been sought—and the interactions with her children and other family members. **She must constantly reassess and reform her identity as she deals with situations she never encountered as a wife.**

The male client must also work through similar adjustments to his self-concept and develop a more realistic self-image. He, too, has socioculturally determined views of himself as a man, a husband, and a divorced person. The therapist must remember that the capacity and need for intimacy often differ in men and women, so the same theories of interpersonal growth do not apply to both.

The reactions of the former spouses to each other are also useful in revealing usual patterns of interaction. Gradually, the client becomes able to predict the former partner's behavior and to develop more effective responses while learning realistic expectations. The positive aspects of the relationship are acknowledged and regret expressed at their loss. With recognition of the negative aspects of their interaction comes insight into the client's own needs and behaviors. Gradual utilization of those insights in reforming perceptions and actions takes place.

As therapy continues, the now-single person finds enjoyment alone and in a restructured life. Personal growth is reflected in new friendships and relationships. New crises are weathered in new ways, and old patterns become more remote. Therapy begins to conclude. The healing process is not a quick one; it often continues for several years after the divorce. Psychotherapy assists not only with the loss and grief but also in helping understand both partners' roles in the marriage breakdown, thus permitting interpersonal growth.

Divorce then becomes the stimulus for change and can be seen as positively affecting personal development. Self-esteem and personal concepts become more rationally-based, new behavior patterns and coping mechanisms are established, and the person is free to form a new, healthier relationship.

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QUESTIONS BASED ON THIS LESSON

45. In a divorce situation:

    A. The degree to which either party suffers a loss of self-esteem is the same, regardless of previous life experiences

    B. In today's "open" society, humiliation and a sense of failure are no longer common emotional reactions to divorce

    C. When a marital partner has long received little affection or support and was often subject to belittlement, depression with loss of self-esteem is often intensified

    D. Women much more than men see the breakup as a threat to occupational-financial achievements

46. In a divorce situation:

    A. Living standards are rarely reduced

    B. Money is never used as a weapon

    C. Child custody is always approached with concern for what is best for the children

    D. The couple is often too dependent upon and noncritical about advice given by lawyers

47. In carrying out therapy with an individual involved in a divorce situation:

    A. Intrapsychic conflicts should be attended to exclusively; realistic problems should be left to other advisors to solve

    B. Countertransference issues are frequently triggered and require resolution

    C. It is not possible for one therapist to carry out the search for important insights and, at the same time, offer ongoing support

    D. Medications should never be used

48. The middle stage of divorce is commonly marked by:

    A. Relative freedom from financial considerations

    B. Extreme self-esteem deterioration

    C. Uncertainty over the loyalty of family and friends

    D. The advent of post-divorce depression

DIRECTIONS IN MENTAL HEALTH COUNSELING

VOLUME 2 INDEX

***Note*: The bold-faced numerals in each citation represent the corresponding lesson number.**

AA (Alcoholics Anonymous), **7**:4-5, 14-15, 17-19
Acquired immunodeficiency syndrome (*see* AIDS)
Addiction (*see* Alcoholism; Gambling, pathological; Substance abuse)
Adolescents, **10**:13
Affective disorders, **9**:4 (*see also* Depression)
Aggression and disease, **2**:4, 7
AIDS (acquired immunodeficiency syndrome)
  classification system for HIV-associated virus infections, **6**:5-6
  dementia (*see* AIDS dementia)
  fear of contagion, **6**:17-18
AIDS dementia, **6**:3-19
  clinical manifestations, **6**:6-10
    AIDS-related complex (ARC), **6**:7-8
    neoplasms, **6**:8
    neuropsychiatric manifestations, **6**:9-10
    opportunistic infections, **6**:8
    primary HIV infection, **6**:7
  course of illness, **6**:15
  diagnosis, **6**:11-15
    differentiation from functional psychiatric disorders, **6**:12-13
    differentiation from other organic mental disorders, **6**:11-12
    neuropathology, **6**:14-15
    special investigations, **6**:13-14
  epidemiology, **6**:5-6
  general description, **6**:3-5
  treatment, **6**:15-19
    delirium, **6**:16
    dementia, **6**:18-19
    denial, **6**:17
    depression, **6**:15-16
AIDS-related complex (ARC), **6**:7-8
Al-Anon, **7**:8, 17-19
Alateen, **7**:8, 17, 19
Alcoholics Anonymous (AA), **7**:4-5, 14-15, 17-19
Alcoholism, **5**:17; **9**:13
  co-dependence (*see* Co-dependence)
  (*see also* Substance abuse)
American Academy of Child and Adolescent Psychiatry, **10**:11
American Psychiatric Press Textbook of Psychiatry, **10**:4
Amitriptyline (Elavil), **9**:14, 19
Amoxapine (Asendin), **9**:15, 19, 21
Anger and disease, **2**:4, 6
Anorexia nervosa, **11**:3-13
  and depression, **11**:4-8
    interactions, **11**:6-8
  starvation, **11**:12
  treatment, **11**:10-11
    nutritional rehabilitation, **11**:10
    psychotherapy, **11**:10-11
    tricyclic antidepressants, **11**:10
Antidepressant medication, **3**:15; **8**:15; **9**:14-21; **11**:5, 10, 12
  (*see also* Tricyclic antidepressants)
Antipsychotic medication, **9**:13
Anxiety, **2**:7; **4**:14-16; **12**:4, 14
ARC (AIDS-related complex), **6**:7-8
Automatic Thoughts Questionnaire, **3**:5
Autonomy and health, **2**:7, 9
Aversion therapy, **8**:12
Avoidant personality style, **8**:7
Azidodeoxythymidine (AZT), **6**:19

Baby role (co-dependence), **7**:12
Beck, A.T., **3**:4-5, 8, 10, 17
Behavioral techniques, **3**:15
  bulimia nervosa, **11**:12
  cancer and coronary heart disease prevention, **2**:10
  depression, **3**:12
Borderline personality disorder, **3**:17; **10**:7, 9
Boss, M., **4**:9, 17-18
Brain
  imaging studies for AIDS dementia, **6**:13
  immune system, interactions with, **5**:5-6, 11-14
Bulimia nervosa, **11**:3-13
  cardiac disorders and suicide, **11**:12
  and depression, **11**:5-6
    interactions, **11**:8-10
  treatment, **11**:11-12
    antidepressants, **11**:5, 12
    interrupting binge-purge behavior, **11**:11-12
Buspirone (BuSpar), **9**:17

California Personality Inventory, **8**:11
Cancer (*see* Psychological factors and cancer and coronary heart disease)
CDC (Centers for Disease Control), **6**:5, 17
Cerebrospinal fluid examination, **6**:14
Cermak, T.L., **7**:13, 16
Child protection movement model (for treating incest), **10**:13
Children
  custody, **12**:12
  incest, **10**:13
    (*see also* Incest, therapy of clients with childhood history of)
Children of Alcoholics (COA), **7**:8, 15-19
Chlorpromazine (Thorazine), **9**:17
Cholesterol level, **2**:9
Cigarette smoking, **2**:4, 9; **5**:17
COA (Children of Alcoholics), **7**:8, 15-19
Co-dependence, **7**:3-19
  arguments against co-dependence diagnosis, **7**:9
  definition, **7**:6-8
  diagnosis, **7**:13-14
  examples, **7**:9-10
  general description, **7**:3-7, 14-15, 19
  psychotherapeutic implications, **7**:17-19
  roles, **7**:10-12
    enabler, **7**:10-11
    family hero, **7**:11
    impact of, **7**:12-13
    lost child, **7**:11
    mascot or baby, **7**:12
    scapegoat, **7**:11

treatment perspective, **7**:16-17
12-step programs, **7**:4-5, 8, 14-19
attendance by therapists, **7**:17-18
(*see also* Dependence)
Co-Dependents Anonymous (CoDA), **7**:8, 16, 18-19
Cognitive therapy for bulimia nervosa, **11**:12
Cognitive therapy for depression, **3**:3-18
cognitive model, **3**:4-9
cognitive triad, **3**:5-6
distorted cognitions, **3**:4-5
logical errors, **3**:7-8
premise of, **3**:4
silent assumptions, **3**:6-8
effectiveness, **3**:15-18
predicting response to, **3**:17-18
general description, **3**:3-4, 18
process and techniques, **3**:9-15
evaluating validity of cognitions, **3**:12-15
frequency, length and modality, **3**:14-15
homework, **3**:14
rationale, **3**:10
self-monitoring, **3**:10-12
therapeutic alliance, **3**:9-10
Commission on the Review of the National Policy Toward Gambling, **8**:4
Comprehensive Textbook of Psychiatry, **10**:4
Conduct disorders, **10**:7
Conscience, **4**:16
Contract, psychological, **1**:9-13
Coping With Depression, **3**:10
Coronary heart disease (*see* Psychological factors and cancer and coronary heart disease)
Counselors
gender differences between client and counselor, **10**:15
sexual involvement with clients, **10**:9
Countertransference, **6**:17; **9**:11
Crying in mentally ill patients, **9**:5-6
Cryptococcus, **6**:8
Custody, **12**:12
Cytomegalovirus, **6**:8

Daily Record of Dysfunctional Thoughts, **3**:10-11
Delirium (AIDS clients), **6**:16
Delusions, **3**:17; **9**:12-13
Dementia (*see* AIDS dementia)
Dependence, **1**:6-7, 10-11; **7**:14; **12**:6-7, 10-11
(*see also* Co-dependence)
Depression
AIDS clients, **6**:9, 12, 15-16
cancer and, **2**:5-6
cognitive therapy (*see* Cognitive therapy for depression)
divorce and, **12**:4, 14
eating disorders and (*see* Eating disorders and depression)
elderly clients (*see* Elderly clients, depression and)
gambling and, **8**:7-8
immune system and (*see* Immune system and depression)
the past and, **4**:7
Desipramine (Norpramin), **9**:14-15, 19
Dextroamphetamine (Dexedrine), **9**:18
Diazoxide (Hyperstat), **9**:17
Diet, **2**:4; **5**:17-18
precautions with MAOIs, **9**:17
Differential diagnosis
AIDS dementia, **6**:11-15
co-dependence, **7**:13-14
depression in elderly clients, **9**:4-5, 7-10
Disease, psychological factors and (*see* Psychological factors and cancer and coronary heart disease)
Divorce as a developmental catalyst, **12**:3-17
general discussion, **12**:3-4
initial stage, **12**:5-13
child custody concerns, **12**:12
dependency needs, **12**:10-11
financial considerations, **12**:11
legal process, **12**:12-13
prior socialization, **12**:6-9
psychological effects of the marriage, **12**:9-10
middle stage, **12**:13-14
resolution, **12**:14-17
Doxepin (Sinequan), **9**:14-15
Drug toxicity and drug interactions (elderly clients), **9**:8
DSM criteria
bulimia nervosa, **11**:8
co-dependence, **7**:7-8, 13
dementia, **6**:6
depression, **9**:5-6, 8-10; **11**:10
incest and sexual abuse (absence from manual), **10**:4
pathological gambling, **8**:4
substance use disorders, **7**:4
Dysfunctional Attitudes Scale, **3**:6
Dyskinesia, tardive, **9**:7, 15

Eating disorders and depression, **11**:3-13
anorexia nervosa (*see* Anorexia nervosa)
bulimia nervosa (*see* Bulimia nervosa)
general discussion, **11**:3-6, 13
Elderly clients, depression and, **9**:3-21
choosing to die, **9**:6-7
crying, **9**:5-6
diagnosis, **9**:4-5, 7-10
associated cognitive changes, **9**:8-10
general discussion, **9**:3-4
grief, **9**:13
incidence, **9**:4, 12
pharmacologic treatments, **9**:14-21
cardiac conditions and, **9**:14, 19-21
delusionally depressed clients, **9**:12-13
heterocyclic agents, **9**:14-15
lithium, **9**:18-21
MAOIs, **9**:16-17, 19-21
psychostimulants, **9**:18
thyroid hormone, **9**:18-19
psychotherapy, **9**:11-12
psychotic depression, **9**:12-13
Electroconvulsive therapy, **9**:17
ELISA (enzyme-linked immunosorbent assay), **6**:13
Enabler role (co-dependence), **7**:10-11
Epidemiology
AIDS dementia, **6**:3-19
incest, **10**:6-7
Existential aspects of psychotherapy, **4**:3-21
anxiety, **4**:14-16
choice, **4**:13-14
embodiment, **4**:11

existence
essence and, **4**:12-13
meaning of, **4**:5
priority of, **4**:11-12
general description, **4**:3, 18-21
guilt, **4**:16-17
object-subject split, **4**:9-10
phenomenology, **4**:10
relevance of philosophy, **4**:4
school of existential therapy (absence of), **4**:5, 18-19
time, **4**:6-8
unconscious, **4**:17-18
Existential guilt, **4**:16-17
Eysenck, H.J., **2**:4

Families
anorexia nervosa, **11**:7
pathological gambling, **8**:4
Family hero role (co-dependence), **7**:11
Family therapy, **10**:13
Feminist model (for treating incest), **10**:13
First National Conference on Co-Dependency, **7**:7
Fluoxetine (Prozac), **9**:15, 17
Freud, Sigmund, **4**:4, 10, 14, 16; **8**:5; **10**:10

Gambler's Anonymous (GA), **8**:13
Gambling, pathological, **8**:3-15
addictive cycle, **8**:8-10
clinical management, **8**:10-15
cardiovascular and stress-related disorders, **8**:10
definition, **8**:4
general description, **8**:3
personality dynamics, **8**:5-6
prevalence, **8**:4-5
subtypes, **8**:7-8
depressed gambler, **8**:7-8
narcissistic gambler, **8**:8
Geriatric clients (*see* Elderly clients)
Germany, study population from, **2**:7-9, 11
Greenberg, R., **8**:10
Grief, **9**:13
Group therapy, **2**:11; **3**:15; **8**:12, 14; **10**:13
Guilt, **4**:16-17

Hallucinations, **3**:17
Hazelden Clinic, **7**:19
Heart disease (*see* Psychological factors and cancer and coronary heart disease)
Heidegger, Martin, **4**:6-8, 10
Heidelberg, Germany, study population from, **2**:7-9, 11
Herpes simplex, **6**:8, 12
Heterocyclic agents, **9**:14-15
HIV (human immunodeficiency virus)
infection, **6**:6-10
risk-reducing behaviors for persons with, **6**:17
(*see also* AIDS)
Homework (cognitive therapy), **3**:14
Hostility and disease, **2**:4
Human immunodeficiency virus (*see* HIV)
Hypersomnolence, **6**:10-11
Hypothyroidism, **8**:11; **9**:7-8
Hypoxemia, **6**:12

Identification, **4**:9
Imipramine (Tofranil), **9**:14, 19-20
Immune system and depression, **5**:3-19
associated behavioral changes, **5**:17-18
brain and immune systems, interactions between, **5**:5-6, 11-14
general discussion, **5**:3-4, 19
immune status in depressed clients, **5**:14-16
immune system overview, **5**:6-10
measures of immunocompetence, **5**:10-11
neuroendocrine system, **5**:5-6, 11-14
Incest, therapy of clients with childhood history of, **10**:3-18
definition of incest, **10**:5-6
epidemiology, **10**:6-7
evaluation, **10**:9-10
general discussion, **10**:3-5, 17-18
"incest syndrome," **10**:12
legal remedies, **10**:16
mental disorder and incest, **10**:7-9
prevention, **10**:17
treatment
boundaries, **10**:15-16
disclosure, **10**:16
goals, **10**:13
indications for, **10**:11-12
methods, **10**:13-15
outcome, **10**:16-17
validity of incest reports, **10**:10-11
Independence, **2**:7

Jacob-Creutzfeldt disease, **6**:4
Job-related stress (*see* Stress in the workplace)

Labetalol (Trandate), **9**:17
Legal considerations
damages suffered through incest, **10**:16
divorce process, **12**:12-13
Levinson, Harry, **1**:4
Levinson Institute, **1**:22
Lithium, **8**:15; **9**:18-21
Lost child role (co-dependence), **7**:11
L-triiodothyronine (T_3, Thyrolar), **9**:18
Lymphadenopathy, **6**:8
Lymphoma, **6**:9

MAOIs (monoamine oxidase inhibitors) for depressed elderly clients, **9**:16-17, 19-21
orthostatic hypotension, **9**:16
toxic interactions with drugs and aged cheese, **9**:17
Maprotiline (Ludiomil), **9**:15, 19, 21
Mascot role (co-dependence), **7**:12
May, Rollo, **4**:18
Medical model (for treating incest), **10**:13-14
Memory disturbances in AIDS dementia, **6**:4
Meningitis, **6**:12
Mental Status Questionnaire, **9**:10
Meperidine hydrochloride (Demerol), **9**:17
Methylphenidate (Ritalin), **9**:18
Mini-Mental State Exam, **9**:9
Minnesota Model, **7**:4
Minnesota Multiphasic Personality Inventory (MMPI), **8**:11
Mitogen responses, **5**:17-18
Monoamine oxidase inhibitors (*see* MAOIs)
Multiple personality disorder, **10**:7, 9

Narcotics Anonymous (NA), **7**:5, 17
Narcissism, **7**:14; **8**:5, 8
National Center on Child Abuse and Neglect, **10**:6
Neuroendocrine system, **5**:5-6, *11-14*
Neuroleptics, **6**:16, 18
NK (natural killer) cells, **5**:17
Nortriptyline (Aventyl), **9**:14-15, 19-20

Organic brain syndrome, **3**:17
Orthostatic hypotension, **9**:16, 19

Parkinsonism, **9**:7, 15
Pathological gambling (*see* Gambling, pathological)
Peer counseling, **8**:12-13
Pharmacologic treatment
  depression, **3**:15-16
    among elderly clients, **9**:14-21
  pathological gambling, **8**:15
  see also entries for types of medications (e.g., Antidepressant medications; Heterocyclicagents) and specific medicationnames (e.g., Amitriptyline; Imipramine)
Phenelzine, **9**:19
Phenomenology, **4**:10
Phentolamine (Regitine), **9**:17
Post-traumatic stress disorder, **10**:7, 9
Priapism (with trazodone), **9**:15
Procainamide (Pronestyl), **9**:21
Projection, **4**:9
Protriptyline (Vivactil), **9**:14-15
Psychoanalysis, **10**:13
Psychological factors and cancer and coronary heart disease, **2**:3-15
  general discussion, **2**:3-7, 15
  prevention of disease, **2**:8-12
  prolonging life of diseased persons, **2**:13-15
  studies
    group therapy, **2**:11
    individual treatment, **2**:10, 12
    intervention, **2**:9-10
    population, **2**:7-8
    results, **2**:8-9
Psychosis, **9**:12-13; **10**:7
Psychosomatic medicine, **2**:4; **4**:11, 20
Psychostimulants, **9**:18
Psychotherapists (*see* Counselors)
Psychotherapy
  anorexia nervosa, **11**:10-11
  aversion therapy, **8**:12
  behavioral (*see* Behavioral techniques)
  clients with history of incest (*see* Incest, therapy of clients with childhood history of)
  co-dependence, **7**:17-19
  cognitive (*see* Cognitive therapy for bulimia nervosa; Cognitive therapy for depression)
  elderly clients, **9**:11-12
  existential aspects of (*see* Existential aspects of psychotherapy)
  family therapy, **10**:13
  group therapy, **2**:11; **3**:15; **8**:12, 14; **10**:13
  psychoanalysis, **10**:13
  self-study, **2**:12
  time and, **4**:6-7
Pyridoxine (Aminoxin), **9**:16

Questionnaires (*see* Tests, scales, and questionnaires)
Quinidine (Cardioquin), **9**:21

Roles in co-dependence, **7**:10-12

Sartre, J.-P., **4**:11-12
Scales (*see* Tests, scales, and questionnaires)
Scapegoat role (co-dependence), **7**:11
Schizoaffective disorders, **3**:17
Schizophrenia, **10**:7
Self-confidence, **2**:7
Self-esteem, **1**:7-8; **2**:7; **12**:5, 9-10, 13
Self-identity, **12**:5, 9
Self-study, **2**:12
Sexual abuse (*see* Incest, therapy of clients with childhood history of)
Sleeplessness, **5**:17-18
Smoking, **2**:4, 9; **5**:17
Sodium nitroprusside (Nitropress), **9**:17
Stress and disease, **2**:4, 6
Stress and pathological gambling, **8**:10
Stress in the workplace, **1**:3-22
  adaptation concepts, **1**:13-14
  diagnostic process, **1**:18-19
  examples, **1**:19-21
  general description, **1**:3-5
  interpersonal model, **1**:8-9
  prevention, **1**:21-22
  psychodynamic model, **1**:5-8
    dependency, **1**:6-7
    drives, **1**:5-6
    ego ideal and self-esteem, **1**:7-8
  psychological contract, **1**:9-13
    change, **1**:12-13
    distance, **1**:11-12
    interpersonal dependence, **1**:10-11
  stress overview, **1**:14-18
    relationship with superior, **1**:14-15
  treatment process, **1**:19
Substance abuse, **7**:4-5, 7, 10-11, 13-16, 19
  family members (*see* Co-dependence)
  pathological gambling and, **8**:4
  (*see also* Alcoholism)
Succinylcholine (Anectine), **9**:17
Suicide, **9**:4; **11**:12
Superego, **4**:16
Syphilis, **6**:4

Tardive dyskinesia, **9**:7, 15
Taxoplasma gondii, **6**:8
Tests, scales, and questionnaires
  Automatic Thoughts Questionnaire, **3**:5
  California Personality Inventory, **8**:11
  Daily Record of Dysfunctional Thoughts, **3**:10-11
  Dysfunctional Attitude Scale, **3**:6
  Mental Status Questionnaire, **9**:10
  Mini-Mental State Exam, **9**:9
  Minnesota Model, **7**:4
  Minnesota Multiphasic Personality Inventory (MMPI), **8**:11
Therapeutic alliance, **3**:9-10; **10**:15
Therapists (*see* Counselors)

Therapy (*see* Psychotherapy)
Thyroid disorders, **8**:11; **9**:7-8, 18-19
Tillich, P., **4**:15
T lymphocytes, **6**:7-8
Touching geriatric clients, **9**:12
Toxoplasmosis, **6**:12
Transference, **4**:6, 9
Trazodone (Desyrel), **9**:15, 19
Treatments of Psychiatric Disorders, **10**:4
Tricyclic antidepressants, **6**:16; **9**:13, 20-21; **11**:10
(*see also* Antidepressant medication)
Trimipramine (Surmontil), **9**:15
12-step programs, **7**:4-5, 8, 14-19
Type A-type B behavior, **2**:4

Unconscious, **4**:17-18

Vitamin A, **5**:18
Vitamin B_6, **9**:16
Vitamin B_{12}, **9**:8
Vitamin E, **5**:18

Workplace, stress in (*see* Stress in the workplace)

Yugoslavia, study population from, **2**:7-8